DATA SPECIFICATIONS FOR THE MDS 2.0 (1/30/98 UPDATE)
VERSION 1.10

FOR NATIONAL IMPLEMENTATION IN APRIL 2000

November 9, 1999

NOTICE:

SPECIFICATIONS FOR MDS 2.0 (1/30/98 UPDATE) SUBMISSION FILES
FOR SUBMISSION FROM THE NURSING HOME TO THE STATE
(Version 1.10)

CONTENTS

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MAJOR CHANGES WITH VERSION 1.10

Version 1.10 of the MDS data specifications has been developed with the primary purpose of implementing a new, expanded MDS Correction Policy nationally in April 2000. A detailed "MDS Correction Policy Provider Manual" will be completed and posted on the HCFA World Wide Web site in the near future. This manual will present detailed description of the new Correction Policy, provider instructions for implementing that policy, and item-by-item instructions for a new Correction Request Form.

In Version 1.10, new data records and fields have been added to support the new Correction Policy. Along with the new correction policy, this version also implements enhanced record rejection. All field range errors and most field formatting and consistency errors have been elevated to fatal errors. It is anticipated that the new correction policy coupled with enhanced record rejection will improve data accuracy in MDS databases at the facility, State, and federal levels.

Another important change with Version 1.10 is the addition of requirements to report whether the resident's unit at the time of the MDS event (assessment, discharge, or reentry) is Medicare/Medicaid certified or not and also to report whether the facility thinks that the State requires MDS submission if the unit is non-certified. These new requirements will allow the State to determine if MDS data is submitted when such submission is prohibited and would violate the resident's privacy rights. (More details are provided in the section entitled "Submission of MDS Records for Residents on Non-Certified Units" below.)

Other changes with Version 1.10 include (1) revision of record locking and submission timing requirements that will be outdated with the new correction policy, (2) addition of new field consistency requirements for the depression items E1 and E2, (3) addition of new field consistency requirements for the Activities of Daily Living (ADLs) in MDS items G1 and G2, (4) addition of new field consistency requirements for the ulcer items in M1 and M2, and (5) correction of several errors and inconsistencies found in Version 1.03 of the data specifications.

The new correction policy and enhanced record rejection are being tested in a pilot project in the State of Washington in late 1999 and early 2000. Two special versions of the data specifications, Versions 1.04 and 1.05, have been developed for use in the Washington pilot project. Versions 1.04 and 1.05 are only being used in the State of Washington until April 2000. In April 2000, Version 1.10 will be implemented in all States nationally.

Version 1.10 of the data specifications is appropriate for use with the MDS 2.0 Assessment and Tracking Forms dated 1/30/98 and with a new MDS 2.0 Correction Request Form. The new Correction Request Form for national implementation in April 2000 is not available at the present time. It is expected to be finalized and released by the Health Care Financing Administration (HCFA) in the near future. A copy of the pilot project Correction Request Form being used in the State of Washington is being distributed in the file CRFM105B.PDF with Version 1.10 of the data specifications. It is anticipated that the national form will be quite similar to the Washington pilot form (more details are provided in the section entitled "MDS Correction Request Form For National Implementation" below).

SPECIFICATIONS FOR MDS 2.0 (1/30/98 UPDATE) SUBMISSION FILES
FOR SUBMISSION FROM THE NURSING HOME TO THE STATE
(Version 1.10)

A more detailed description of the changes that are being made from Version 1.03 to Version 1.10 can be found in the separate document ***CH103_10.PDF***.   (For participants in the Washington Pilot Project, a separate document ***CH105_10.PDF*** details the changes from Version 1.05 to Version 1.10.)

SUGGESTIONS FOR DEVELOPING MDS SOFTWARE

A few suggestions for MDS software developers.

1. With the enhanced record rejection in Version 1.10, very careful attention must be given to field range and consistency requirements, since errors will now often lead to record rejection.

2. With implementation of the new Correction Policy, it will be desirable that MDS software prints the MDS Correction Request form.

3. The rules concerning the submission of the MDS Facesheet (Sections AB and AC) should be carefully reviewed. There has been confusion concerning Facesheet requirements in the past, and these requirements have been clarified in Version 1.10.

4. The Medicare PPS system incorporates a very rigorous assessment schedule involving assessments at about day 5, day 14, day 30, day 60, and day 90 of a Medicare Part A covered stay. This schedule means that it is quite likely to have 2 different assessments active for the same resident at the same time. A Medicare 5-day assessment may not be completed before the Medicare 14-day assessment is started. It would appear to be a desirable feature for MDS software packages to allow 2 active assessments to be opened at the same time.

5. Both the rigorous Medicare PPS assessment schedule and the standard HCFA mandated clinical schedule (admission, quarterly, annual, significant change, and significant correction assessments, as well as discharge and reentry tracking forms) must be satisfied. A desirable software feature would be to assist the facility in managing these demanding schedules.

6. The Medicare PPS system requires the facility to perform complex in-house RUG-III case mix classifications using a range of parameters. Facilities must include resident RUG-III classifications (based on MDS assessments) on Medicare PPS claims forms to receive appropriate payment. It is desirable that MDS software packages accurately perform RUG-III Medicare classifications. Parameters for Medicare PPS RUG-III classifications are subject to frequent change. It is desirable if software take a flexible approach to handling RUG-III parameters such as Case Mix Index (CMI) weights.

MDS CORRECTION REQUEST FORM FOR NATIONAL IMPLEMENTATION

A one-page MDS Correction Request Form for national implementation will be released in the near future. This form is expected to very similar to the one-page Pilot Correction Request Form being used in the pilot

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test in the State of Washington. The Abobe Acrobat download file for the Pilot form is ***CFRM105B.PDF***, and this Pilot form is identified by the text "Washington Pilot 10/14/1999" in the lower right hand corner.

The National Correction Request Form is expected to have exactly the same items and text in exactly the same order with the following two exceptions:

1. On the Pilot form in the Prior Record Section, the word reentry has been incorrectly spelled as "rentry". This error will be corrected on the National form.

2. On the Pilot form the text of the formal attestation language ("Attestation Text" box between the AT4 items and the AT5 item) has been left blank. The formal attestation language will be included on the National form in the space provided.

With the implementation of the new Correction Policy, it will be necessary for facilities to complete Correction Request Forms and place copies in the clinical record.

If the facility is manually completing the Correction Request Form, then the facility should either use the National Correction Form (to be available on the HCFA world wide web site in the near future) or an exact replica of that form.

If the facility prints the Correction Request Form using an MDS software product, then it is ***desirable*** that the resulting printout also be a replica of the national form. Although desirable, it is ***not strictly required*** that Correction Request Forms printed with MDS software be formatted exactly the same as the download form. Forms printed with MDS software will be acceptable as long as the printout contains the exact verbiage and items in the exact order as the download form. It is permissible for fonts, spacing, and number of pages to differ from the download form, as long as all information and ordering is maintained.

MDS CORRECTION POLICY

USE OF AN MDS CORRECTION REQUEST FORM

The MDS Correction Request Form is being implemented as part of the new Correction Policy that allows facilities to correct erroneous MDS data previously submitted and accepted into the State MDS database. A correction request should only be used for records that are actually in the State database. Do not use the Correction Request Form for a record that has not yet been submitted, or for a record that has been submitted, but rejected. If the record in error has not been submitted, or if it has been submitted and rejected, then the facility should correct that record "in-house", before submission or resubmission.

The facility should take corrective action within 14 days of the date an error is detected in a record already accepted in the MDS database. This corrective action involves completion of a modification or inactivation request. As with completion of the original assessment, when modifying or inactivating assessment information, the facility is responsible to ensure the participation of the appropriate health care professionals.

COMPONENTS OF THE CORRECTION REQUEST FORM

The Correction Request Form contains two sections: the "Prior Record Section" and the "Correction Attestation Section". The Prior Record Section is primarily used to identify the erroneous record, so that it can be located in the State MDS database. The Correction Attestation Section includes the sequence number of this correction, relative to other corrections that may have been made to the same original record; the type of correction requested (modification or inactivation); the reason(s) the modification or inactivation is necessary; the name of the facility representative attesting to both the need for correction and the accuracy of the correction, relative to the resident's status as of the event date of the erroneous record (MDS item A3a for an assessment, MDS Item R4 for a discharge, and MDS Item A4a for a reentry); the date of the attestation; and the signature of the attesting facility representative.

Note that the Correction request form does ***not*** include a section for specifying which Item(s) are in error. The facility need not specify which items are being corrected on the Correction Request form. If items are being corrected in a modification request, an entire, corrected record will be submitted with the Correction Request Form (see "Components of a Submission Record", below). The standard MDS system at the State is programmed to identify any differences between the erroneous record and record submitted to correct it. The corrected record essentially "replaces" the erroneous record in the database. The erroneous record is placed in a "history" file, and the State MDS system tracks sequential changes to records.

The Correction Request Form serves several purposes: (1) to request correction of error(s) in an MDS record (assessment, or Discharge or Reentry Tracking form) that has already been accepted by the MDS system at the State; (2) to identify the prior, erroneous record so that it can be located in the State database; and (3) to attest to the accuracy of and the need for the correction request. Using the form, a facility specifies whether the request is to ***Modify*** or to ***Inactivate*** a record.

MODIFICATION VS. INACTIVATION

A ***modification*** should be requested when there is inaccurate data in an MDS record in the State MDS database. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, or errors caused by vendor software. Inaccuracies can occur either in KEY identification fields (e.g., resident name, Social Security Number, or reasons for assessment) or in non-KEY fields. Regardless of the reason for the error, or whether the item is KEY or not, the facility completes a Correction Request Form indicating that "modification" is the action requested at Item AT2 on the form. In addition, for a modification, the facility also completes a corrected MDS assessment or tracking form.

An ***inactivation*** should be requested when the record should not actually have been submitted, for example, if a Discharge Tracking form were submitted for a resident who was not discharged, or if a test record was inadvertently submitted as a production record. When an erroneous record requires inactivation, the facility completes a Correction Request form indicating that "inactivation" is the action requested at Item AT2 on the form.

COMPONENTS OF AN MDS SUBMISSION RECORD

A major change with the new Correction Policy is that a submission record from the facility now includes new sections to accommodate information contained in a Correction Request Form. A single submission record now includes areas for **both** an MDS record (assessment, or Discharge or Reentry Tracking form) **and** correction request information. The "Overview of MDS Submission Record" in Figure 1 depicts the contents of a submission record. Submission records may include either data from the MDS assessment or tracking form, or information from the correction request form, or both, depending on whether submission record is for an original MDS record, an inactivation request, or a modification request.

For a modification, **both** the information on the Correction Request Form **and** the corrected assessment or tracking form is encoded into a single, electronic submission record according to HCFA's standard MDS Data Specifications. This submission record includes data from the **entire**, corrected MDS assessment or tracking form, **not just** the corrected values for the items that were in error. A modification can be used to correct KEY items (resident identifiers; reasons for assessment; and the date of assessment, discharge, or reentry) and/or non-KEY Items.

For an inactivation, the facility encodes the information from the Correction Request Form into an electronic submission record according to HCFA's standard MDS Data Specifications. In this case, the submission record contains the correction request information **only**. This provides sufficient information for the erroneous MDS record to be located and inactivated in the State database. For an inactivation, corrected MDS assessment or tracking form data is not included in the submission record.

Figure 1.

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

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

Submission Record

Correction Request Items / MDS Assessment or Tracking Form Items
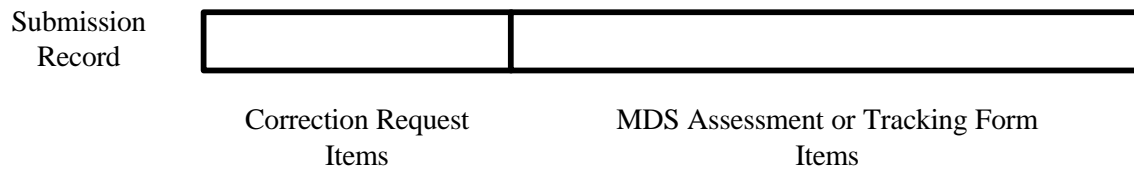
The contents of a submission record vary depending upon whether the record is an original submission, a modification request, or an inactivation request, as displayed below:

Original Submission Record

BLANK / INCLUDED

Correction Request Items / MDS Assessment or Tracking Form Items

Modification Request Record

INCLUDED / INCLUDED

Correction Request Items / MDS Assessment or Tracking Form Items

Inactivation Request Record

INCLUDED / BLANK

Correction Request Items

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SPECIFICATIONS FOR MDS 2.0 (1/30/98 UPDATE) SUBMISSION FILES
FOR SUBMISSION FROM THE NURSING HOME TO THE STATE
(Version 1.10)

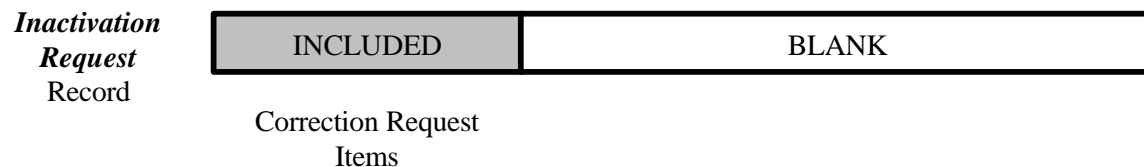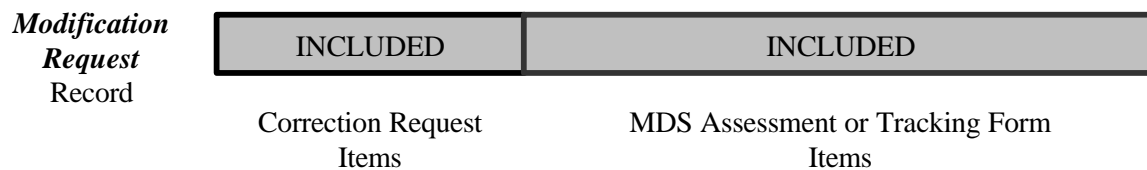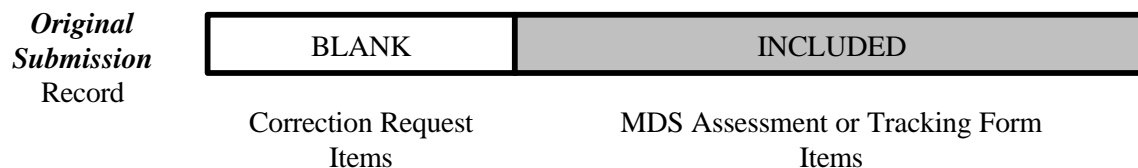## MDS DATA ACCURACY REQUIREMENTS AND DATA CORRECTION POLICY

Each facility is responsible for submitting accurate MDS data and every effort should be made to achieve accuracy. However, some inaccuracies will occasionally occur. For example, the resident's name may have been misspelled, the social security number may have been mis-entered, or the wrong code may have been entered for a clinical item. Such inaccuracies can have serious consequences. Inaccurate data can affect Quality Indicator reports provided both to surveyors and facilities. Inaccurate data can also affect Medicare and Medicaid payments to facilities. When a facility discovers that inaccurate data has been submitted and accepted into the State database, then the new MDS data correction procedures should be used to correct those inaccurate data records. The data correction procedures are intended to insure that the data in the State database matches the actual assessed condition of the resident at the time of assessment (e.g., assessment reference date in item A3a).

The implementation of data correction procedures in no way precludes the need for the existing "clinical correction" process. MDS clinical guidelines must be followed and new "significant change" and "significant correction" assessments must still be performed when appropriate.

The data correction process in no way precludes the need for "significant change" assessments. If the resident's condition has changed since the last assessment, a data correction is completely inappropriate for reporting this change. Rather, when a resident has experienced a significant change in condition, a new "significant change" assessment must be performed, involving new observation of the resident, a new assessment reference date, and appropriate changes to the resident's care plan. A data correction for an assessment is a request to correct an existing record and does not involve a new assessment with a new observation period. A data correction cannot be used to record actual changes to a resident's condition. It cannot substitute for a significant change assessment. To do so would jeopardize the clinical integrity of the MDS process.

Similarly, the data modification process in no way precludes the need for "significant correction" assessments. If the resident's condition has been clinically mis-assessed, then the facility should review the situation and determine if the error is major. If the error is major (e.g., an inappropriate care plan has resulted), a new "significant correction" assessment must be performed, involving new observation of the resident, a new assessment reference date, and appropriate changes to the resident's care plan. A data modification cannot be used in lieu of this clinical correction process. If there are data errors in the prior assessment record in the State database, then both a modification request to the prior record and a new significant correction assessment may be appropriate. A data modification cannot simply substitute for a significant correction assessment. To do so would jeopardize the clinical integrity of the MDS process.

MDS RECORD LOCKING REQUIREMENTS

Version 1.10 of the data specifications removes the requirements that records be locked in the facility before submission and acceptance into the State database. The Assessment Lock Date (ASMT_LCK) and Care Planning Lock Date (CARE_LCK) are no longer required to be accounted and submitted.

Analysis has indicated that the previous Assessment Locking and Care Planning Locking requirements in Version 1.03 may produce complexities with the new Correction Policy. Consider the following example. A facility creates and locks an MDS record in preparation for submission. A data error is then discovered in the locked record before submission. Since the record is locked, the facility cannot change the record. The only alternative is to submit the record in error. The new Correction Policy would then allow the facility to request correction of the record once it is in the State database. However, this is an awkward process requiring the facility to submit a known error in order to correct it. It would seem much easier if the facility could simply correct the original record anytime before submission. In this case, the record would not be locked in the facility, but rather would be locked upon its acceptance into the State database.

There are even more severe problems when record locking in the facility is required with the enhanced record rejection being implemented in Version 1.10. With enhanced record rejection, the traditional requirements concerning the locking of MDS data records will become even more difficult for the facility to manage. Traditional record locking requires that the record be locked in the facility, prior to submission to the State. Only after locking and then submission to the State, will the facility be informed if a record is rejected because of data errors. When a record is rejected, the facility must unlock the record, correct only the errors causing rejection, and resubmit the record. If a record must be unlocked and corrected, then the usefulness of the locking concept is questionable.

Because of such problems, a revised approach to record locking is being implemented in Version 1.10 along with the new Correction Policy. With this revised approach, an MDS record is considered locked only when accepted into the State database. This means that there is no need to lock the record in the facility prior to submission and acceptance into the State database. No record locking prior to acceptance is required in Version 1.10 of the data specifications.

The concept of locking an MDS record was originally developed to insure the clinical integrity of the MDS assessment process. The "Long Term Care Resident Assessment Instrument User's Manual" for MDS 2.0 introduced the concept. That manual describes the MDS assessment as being "closed" (completed) according to the regulatory timeframe. Amendments can then be made to any item during the next 7 day period, provided that the same Assessment Reference Date is used (A3a). In other words, to ensure clinical integrity, the MDS record should be locked within seven days of completion. After locking no further changes may be made.

If record locking is to be moved to the point of acceptance into the State database, consideration must be given to shortening the submission requirements. HCFA's current submission requirement is that an assessment record should be submitted within 31 days of the final lock date. If locking within the facility is discontinued, then the submission requirement could no longer be based on the lock date, and the requirement would be translated into submission within 31 days of completion. In Version 1.10, the MDS submission requirement is being changed to 31 days after completion of an assessment rather than 31 days after final locking (see next section "MDS Submission Timing Requirements").

If record locking is delayed until acceptance by the State and a 31 day submission window is maintained, then the locking requirement for an MDS assessment will have been extended from a 7 day period to a 31 day period. A 31 day period seems unreasonably long to be without assurance that the record is closed and

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no changes will be made. This is clearly undesirable and will certainly compromise the clinical integrity of MDS assessments. Consider an example. The reference date for observing a resident is set as September 1. The assessment is then completed on September 14, within the regulatory guidelines. The record is then submitted and accepted (locked) on October 15 (31 days after completion). There is concern that changes might be made to the MDS, a clinical document representing the resident's condition on September 1, as long as 45 days after that date.

The dilemma is that locking records in the facility (before submission) creates excessive complexity when coupled with enhanced record rejection and the new Correction Policy, while locking records upon acceptance compromises the clinical integrity of the MDS *if* the current wide submission window is maintained. The solution being adopted by HCFA is to eliminate the requirements for locking within the facility with Version 1.10, and then reduce the submission time frame in the future. Ideally, the submission requirement could eventually be shortened to 7 days after completion. This would mean that records would usually be locked (accepted) within 7 days, mirroring the traditional MDS locking policy. The current 31 day submission window seemed appropriate several years ago, when facility automation was in its infancy and many facilities were employing diskette submission through the mail. Today, with better facility automation and the requirement for modem transmission to a Standard State MDS system, a shortened submission window seems appropriate. Analysis of MDS records submitted to the States has indicated that the vast majority of providers are submitting within a week or two. With a shortened submission window, if a record containing an error does make it into the State database, that error can still be corrected with the new Correction Policy.

MDS SUBMISSION TIMING REQUIREMENTS

HCFA's MDS automation requirement provides that MDS assessment records, discharge tracking records, and reentry tracking records must be electronically submitted at least monthly from the facility to the State. A further requirement stipulates the timely submission of each record.

In prior versions of the Data Specifications (e.g., Version 1.03), submission requirements were based upon record locking dates. With discontinuation of the record locking requirement in Version 1.10, the submission requirement can no longer be based on the lock dates. The new submission requirements for Version 1.10 are based upon completion dates rather than locking dates as follows.

> **Tracking Forms.** The previous requirement was that discharge and reentry tracking form records must be submitted within 38 days of the occurrence of the event. To be consistent with the revised requirement for assessments, Version 1.10 is changing the requirement for tracking forms to be within 31 days of the event.

> **Assessments.** The previous requirement was that assessment records must be submitted within 31 days of the final lock date (CARE_LCK for comprehensive assessments and ASMT_LCK for other assessments). The new Version 1.10 requirements are submission within 31 days of the completion date (VB4 for comprehensive assessments and R2b for other assessments). The assessment submission requirements are detailed in Table 1.

SPECIFICATIONS FOR MDS 2.0 (1/30/98 UPDATE) SUBMISSION FILES
FOR SUBMISSION FROM THE NURSING HOME TO THE STATE
(Version 1.10)

TABLE 1
SUBMISSION REQUIREMENTS FOR MDS ASSESSMENTS

Assessment Type	Primary Reason (AA8a)	Secondary Reason (AA8b)	Completion Date	Submit By
Admission	01	all values	VB4	VB4 + 31
Annual	02	all values	VB4	VB4 + 31
Sign. Change	03	all values	VB4	VB4 + 31
Sign. Correction Full	04	all values	VB4	VB4 + 31
Quarterly	05	all values	R2b	R2b + 31
Sign. Correction Quarterly	10	all values	R2b	R2b + 31
Medicare PPS (not included above)	00	1 thru 5, 7, 8	R2b	R2b + 31
Other State Required	00	6	State Determined	State Determined

SUBMISSION OF MDS RECORDS FOR RESIDENTS ON NON-CERTIFIED UNITS

There is no federal requirement to submit MDS data for residents on facility units that are not Medicare/Medicaid certified. However, a State may require that MDS data be submitted for a non-certified unit. ***If there is no specific State submission requirement for a non-certified unit, then MDS data is prohibited from being submitted for that unit. It is a violation of a resident's privacy rights to submit MDS data to the State when not required.***

Version 1.10 of the data specifications requires that the facility indicate if an MDS record is being submitted for a resident on a non-certified unit. A new data field (SUB_REQ) must be included on each MDS tracking form or assessment record. This new field has the following values:

    1 (0ne) -- If the MDS event (assessment reference date, discharge date, or reentry date) occurs for the resident while on a unit that IS NOT Medicare/Medicare Certified and the State DOES NOT require MDS submission for this unit. Submission of the record to the State is PROHIBITED.

    2 (Two) -- If the MDS event (assessment reference date, discharge date, or reentry date) occurs for the resident while on a unit that IS NOT Medicare/Medicare Certified and the State DOES require MDS submission for this unit.   Submission of the record to the State is REQUIRED.

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3 (Three) -- If the MDS event (assessment reference date, discharge date, or reentry date) occurs for the resident while on a unit that IS Medicare/Medicare Certified. MDS submission is always REQUIRED for residents on a Medicare/Medicaid certified unit.

For coding of this item, the MDS event date is as follows:
   a. The assessment reference date (A3a) for an assessment record
      (AA8a = 01,02,03,04,05,10, or 00).
   b. The discharge date (R4) for a discharge tracking form record
      (AA8a = 06,07, or 08).
   c. The reentry date (A4a) for a reentry tracking form record
      (AA8a = 09).

If a record is submitted for a non-certified unit, when submission is not required by the State, the Standard State MDS System will reject the record and discard all data without storing any information in the State database. The Final Validation Report from the State System will inform the facility that a prohibited record has been submitted. The prohibited record will only be identified by its ordinal position in the submission file. No resident identifiers or other information will appear on the Final Validation Report.

CLARIFICATION OF MDS 2.0 FACESHEET RULES

MDS Facesheet information (Section AB and AC) is required on each admission assessment record. If the resident is discharged prior to the admission assessment, then 2 facesheet items are required (AB1 and AB2) and the remaining items (AB3 through AC1y) can be submitted at facility option in all or none fashion. For records following the admission assessment for a stay, the entire Facesheet (AB1 through AC1y) may be updated at facility option in all or none fashion.

A more detailed description of these facesheet requirements follows:

I.   FACESHEET (SECTIONS AB AND AC) SUBMISSION REQUIREMENTS:

   1. RECTYPEs A, AM, and AO. All Facesheet items, AB1 through AC1y, are required. If a fatal error occurs for any of these items, then the record will be rejected.

   2. RECTYPE D with AA8a = 08. Items AB1 and AB2 are required and the remaining items (AB3 through AC1y) are optional by facility option in ALL OR NONE fashion (see Optional Submission Provision II.1.a below). If a fatal error occurs for either of the required items (AB1 and AB2), then the record will be rejected.

   3. RECTYPE D with AA8a = 06 or 07 or RECTYPEs Y,YM,YO,Q,QM,QO, and OM. All Facesheet items, AB1 through AC1y, are optional by facility option in ALL OR NONE fashion (See Optional Submission Provision II.1.b below).

   4. RECTYPE O and OO. Facesheet items should not be submitted.

II.   OPTIONAL SUBMISSION PROVISION:

SPECIFICATIONS FOR MDS 2.0 (1/30/98 UPDATE) SUBMISSION FILES
FOR SUBMISSION FROM THE NURSING HOME TO THE STATE
(Version 1.10)

1. ALL OR NONE Optional Submission requirement:

   a. For RECTYPE D with AA8a = 08, the optional Facesheet items, AB3 through AC1y, must be submitted in ALL OR NONE fashion. Either all of the AB3 through AC1y items must be skipped or all must be completed. If some are skipped and some are completed, then the record will be rejected. If completed, each optional item must conform to the Format Info, Range and Consistency specifications and fatal errors will lead to record rejection.

   b. For RECTYPE D with AA8a = 06 or 07 or RECTYPEs Y,YM,YO,Q,QM,QO, and OM, the optional Facesheet items, A1B through AC1y, must be submitted in ALL OR NONE fashion. Either all of the AB1 through AC1y items must be skipped or all must be completed. If some are skipped and some are completed, then the record will be rejected. . If completed, each optional item must conform to the Format Info, Range and Consistency specifications and fatal errors will lead to record rejection.

2. Other Optional Submission requirements:

   a. AB11 should contain the latest date that the Facesheet information has been updated.

   b. For RECTYPE D with AA8a = 06 or 07 or RECTYPEs Y,YM,YO,Q,QM,QO, and OM, if the optional Facesheet items, A1B and AB2 are submitted, then the values for these two items should be the same as previously submitted during the current stay for the resident in the facility.

FATAL AND NONFATAL ERRORS IN MDS DATA SUBMITTED TO THE STATE

When MDS 2.0 data files are submitted to the State, the submission file and each component record is validated against standard data specifications by the standard State MDS system. Detail feedback reports to the facility indicate all errors found in MDS data submitted. Most MDS data errors involve bad values for a particular data field, and, with Version 1.10 of the MDS data specifications, the majority of these errors are **fatal**. That is the data record involving the error is rejected and must be corrected and resubmitted to the State. Feedback concerning the error is reported back to the facility to allow correction and resubmission.

If no fatal errors are detected, then any non-fatal errors will be reported to the facility by the standard State MDS system and the MDS record will be accepted into the State MDS database. Facilities should attempt to limit non-fatal errors, since frequent or repetitive errors may lead to sanctions.

There are two different types of fatal errors.   Some fatal errors involve file integrity and lead to rejection of an entire MDS submission file--these are **fatal file errors**. Other fatal errors involve range or consistency errors for specific fields within an MDS record and such errors lead to rejection of the single record with errors--these are **fatal record errors**.

FATAL FILE ERRORS

Fatal file errors involve problems with the basic integrity of the submission file (detailed description of a submission file appears later in this document). A submission file consists of a header record with appropriate identifiers, followed by MDS data records, and ending with a trailer record. Header, data, and trailer records are described in more detail later in this document, and detailed field-by-field specifications are presented in other documents included with Version 1.10 of the specifications (see below). The following errors are considered fatal file errors and will lead to rejection of an entire submission file:

1. The primary facility identifier in the header record (FAC_ID) does not match the log-in ID or does not exist in the State database.

2. The primary facility identifier (FAC_ID) in any MDS data record does not match that in the header record.

3. Any record (header, data, or trailer) is of nonstandard length.

4. The header or trailer record is missing or out of order.

5. There are no MDS data records or the data records are out of order.

6. The record count given in the trailer record does not match the total number of records in the submission file.

When a fatal file error occurs, the facility must correct its MDS software to produce an acceptable submission file, and then resubmit the file.

FATAL RECORD ERRORS

An individual MDS data record will be rejected if there is a fatal range, format, or consistency error for any field in the record. Detail listings of all fatal range and consistency errors are provided in the detailed specifications for the MDS data record (in the files D_DT110A.PDF, D_DT110B.PDF, and D_DT110C.PDF). An individual MDS record will also be rejected if there is insufficient information to identify the resident or if a duplicate record (matching key fields) already exists in the State's database. Such fatal errors occur if:

1. there is insufficient key information to identify the resident, or

2. a duplicate record (same critical key fields) already exists in the State's database.

When a fatal record error occurs, the facility must unlock the MDS record, correct the appropriate fields, and then relock the record. The record can then be resubmitted with the next MDS file transmitted to the State.

KEY CHANGE REQUESTS--DISCONTINUED WITH VERSION 1.10

With prior versions of the MDS data specifications, facilities were instructed to inform the State if key fields in an MDS record were inaccurate and request that the State manually correct those key fields in the State database. With version 1.10 and with the implementation of the new data correction procedures, such key change requests and manual correction are no longer needed and have been discontinued. With version 1.10, when a facility determines that there is an inaccuracy in any MDS field, whether that field is a "key" field or not, then the facility should simply submit a record modification request. A record modification request can be used to automatically correct all inaccurate fields, both key and non-key.

MDS SUBMISSION FILE STRUCTURE

A valid submission file consists of fixed length ASCII records. All records in the file must consist of 1812 data bytes followed by a carriage return (ASCII 013) and then a line feed (ASCII 010) for a total of 1814 bytes. Also byte 1812 of each record must contain a % [percent sign] to indicate end of data.

Each submission file consists of a **Header Record** as the first record, multiple **Data Records**, and a **Trailer Record** as the last record.

Header Record

> The header record has A0 (capital A followed by zero) in the first two bytes. The file H_DT110.PDF contains the document "Header Record Layout (Version 1.10)" which presents a detailed layout for the header record. The header record contains basic identifying information for the facility submitting the MDS 2.0 data and also contact persons and phone numbers to use in the event that the file is in error.

Data Records

> Data records have B0 (capital B followed by zero), M0 (capital M followed by zero), or X0 (capital X followed by zero) in the first two bytes. A B0 indicates an original data record; an M0, a request to modify an existing data record; and X0, a request to inactivate an existing data record. The files D_DT110A.PDF, D_DT110B.PDF and D_DT110C.PDF contain the document "Data Record Layout (Version 1.10)" which presents a detailed layout for the data record. The data record contains information for a single MDS resident assessment, a single discharge transaction, a single reentry transaction (readmission after discharge), a single request to modify an MDS record, or a single request to inactivate an MDS record. There are several different types of assessment and transaction records--for instance one type presents the information from an admission MDS 2.0 assessment, while another presents the information for a discharge. (Record types are discussed in detail in a section below.) All data records consist of exactly the same fields in exactly the same order regardless of record type. A given field

(e.g. date of discharge) may be required on some record types, inactive on other record types, optional on still other record types, and blank filled on still other record types.   The file D_SM110.PDF contains an abbreviated, summary version of the data record layout entitled "Abbreviated Data Record Layout (Version 1.10)".

Trailer Record

The trailer record has Z0 (capital Z followed by zero) in the first two bytes. The file T_DT110.PDF contains the document "Trailer Record Layout (Version 1.10)" which presents a detailed layout for the trailer record. The trailer record indicates the end of the submission file, and this record includes a count of the total records in the file including the Header and Trailer Records.

DATA RECORD TYPES

There are 15 different data record types and these record types are defined and described in Tables on the following 4 pages. Table 2 ("Record Type Determination for the MDS 2.0") gives a code, name, and brief description for each of the 15 record types. Record type is based on the correction "Action Requested" item (AT2) and the "Reasons for Assessment" items (AA8a and AA8b) on the MDS 2.0. Item AA8a is the primary reason for assessment for clinical purposes, while item AA8b is the supplemental reason for assessment relevant to Medicare payment or other State requirements. Table 3 ("Record Type Definition Matrix") gives the record type for each valid combination of AT2, AA8a, and AA8b. Table 4 ("Record Type Structured Logic for MDS 2.0") gives logical statements to define record type based on AT2, AA8a, and AA8b.

Each record type has a different pattern of "active" fields. For each record type, each field in the MDS 2.0 layout is always active (required to have a value included), is always inactive (value is ignored), is always skipped (required to have a blank value), is active at facility option, or is active at state option. Table 5 ("Overview of Items Included by Record Type") gives a summary of which items are included for each record type.

Note that separate record types are required for assessments, discharges, reentries, modification requests, and inactivation requests--i.e., data from these events cannot be combined into a single record. Record Types O and OO refer to state specific (e.g., special assessments or other records required and defined by a particular state for Medicaid purposes) and these record types are largely ignored in the present specifications.

TABLE 2
RECORD TYPE DETERMINATION FOR THE MDS 2.0 (Version 1.10)

The MDS 2.0 (1/30/98 Update) Record Types are as follows:

CODE	NAME	DESCRIPTION
A	Admission	Admission assessment (comprehensive with RAPs)
AM	Admission/Medicare	Admission assessment (comprehensive with RAPs) also used as a Medicare PPS assessment
AO	Admission/Other State	Admission assessment (comprehensive with RAPs) also used as a State required assessment
Y	Yes RAPs	Comprehensive assessment with RAPs (not admission)
YM	Yes RAPs/Medicare	Comprehensive assessment with RAPs (not admission) also used as a Medicare PPS assessment
YO	Yes RAPs/Other State	Comprehensive assessment with RAPs (not admission) also used as a State required assessment
Q	Quarterly	Quarterly update assessment
QM	Quarterly/Medicare	Quarterly update assessment also used as a Medicare PPS assessment
QO	Quarterly/Other State	Quarterly update assessment also used as a State required assessment
O	Other	Other assessment (not standard HCFA required assessment)
OM	Other/Medicare	Other assessment (not standard HCFA required assessment) also used as a Medicare PPS assessment
OO	Other/Other State	Other assessment (not standard HCFA required assessment) also used as a State required assessment
D	Discharge	Discharge tracking record
R	Reentry	Reentry tracking record
X	Inactivation	Record inactivation request

TABLE 3. RECORD TYPE DEFINITION MATRIX
Record Type Codes By AT2, AA8a, And AA8b Responses

MDS 2.0 Record Type is based on the correction action requested in item AT2 and the reason for assessment codes in items AA8a and AA8b. The following table gives the Record Type for each valid combination of these codes. Blank cells in this table are combinations of the three codes (AT2, AA8a, and AA8b) which are not permissible. (This table corresponds to the structured logic given in the next table.)

AT2 (corr. action)	AA8a Value (Primary reason for assessment)	AA8b Value (Codes for Medicare and Other State Assessments)								
		Space	1 (5 day)	2 (30 day)	3 (60 day)	4 (90 day)	5 (Rdm)	6 (Oth St)	7 (14 day)	8 (Oth Mcr)
Blank, 1	01 (Admission assess.)	A	AM				AM	AO	AM	AM
Blank, 1	02 (Annual assess.)	Y	YM	YM	YM	YM	YM	YO	YM	YM
Blank, 1	03 (Sign. Change assess.)	Y	YM	YM	YM	YM	YM	YO	YM	YM
Blank, 1	04 (Sign. Correct. full assess.)	Y	YM	YM	YM	YM	YM	YO	YM	YM
Blank, 1	05 (Quarterly assess.)	Q	QM	QM	QM	QM	QM	QO	QM	QM
Blank, 1	06 (Discharge, return not anticip.)	D								
Blank, 1	07 (Discharge, return anticipated)	D								
Blank, 1	08 (Discharge, prior to init. Assess.)	D								
Blank, 1	09 (Reentry)	R								
Blank, 1	10 (Sign. Correct. quart. assess.)	Q	QM	QM	QM	QM	QM	QO	QM	QM
Blank, 1	00 [zero] (None of above)	O	OM	OM	OM	OM	OM	OO	OM	OM
2	Blank	X								

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TABLE 4
RECORD TYPE STRUCTURED LOGIC FOR MDS 2.0 (Version 1.10)

The following structured logic defines MDS 2.0 (1/30/98) Record Type. (This logic corresponds to the Record Type Definition Matrix on the previous page.)

Record Type = A   IF ((AT2 = Space OR 1) AND (AA8a = 01) AND (AA8b = Space)).
Record Type = AM   IF ((AT2 = Space OR 1) AND (AA8a = 01) AND (AA8b = 1 OR 5 OR 7 OR 8)).
Record Type = AO   IF ((AT2 = Space OR 1) AND (AA8a = 01) AND (AA8b = 6)).
Record Type = Y   IF ((AT2 = Space OR 1) AND (AA8a = 02 OR 03 OR 04) AND (AA8b = Space)).
Record Type = YM   IF ((AT2 = Space OR 1) AND (AA8a = 02 OR 03 OR 04) AND (AA8b = 1 OR 2 OR 3 OR 4 OR 5 OR 7 OR 8)).
Record Type = YO   IF ((AT2 = Space OR 1) AND (AA8a = 02 OR 03 OR 04) AND (AA8b = 6)).
Record Type = Q   IF ((AT2 = Space OR 1) AND (AA8a = 05 OR 10) AND (AA8b = Space)).
Record Type = QM   IF ((AT2 = Space OR 1) AND (AA8a = 05 OR 10) AND (AA8b = 1 OR 2 OR 3 OR 4 OR 5 OR 7 OR 8)).
Record Type = QO   IF ((AT2 = Space OR 1) AND (AA8a = 05 OR 10) AND (AA8b = 6)).
Record Type = O   IF ((AT2 = Space OR 1) AND (AA8a = 00) AND (AA8b = Space)).
Record Type = OM   IF ((AT2 = Space OR 1) AND (AA8a = 00) AND (AA8b = 1 OR 2 OR 3 OR 4 OR 5 OR 7 OR 8)).
Record Type = OO   IF ((AT2 = Space OR 1) AND (AA8a = 00) AND (AA8b = 6)).
Record Type = D   IF ((AT2 = Space OR 1) AND (AA8a = 06 OR 07 OR 08) AND (AA8b = Space)).
Record Type = R   IF ((AT2 = Space OR 1) AND (AA8a = 09) AND (AA8b = Space)).
Record Type = X   IF (AT2 = 2).

TABLE 5
OVERVIEW OF ITEMS INCLUDED BY RECORD TYPE

Record Type	Attestation (AT1 – AT6)	Section AA	Sections AB,AC Facesheet	Sections A - R MDS Items	Section S	Section T	Section U	Section V RAPs	Prior IDs (Prior_Fields)
A, AO	Req. if AT2=1 [a]	Required	Required	Full set	State option	State option	State option	Required	Req. if AT2=1 [a]
AM	Req. if AT2=1 [a]	Required	Required	Full set	State option	Required	State option	Required	Req. if AT2=1 [a]
Y, YO	Req. if AT2=1 [a]	Required	Facility option	Full set	State option	State option	State option	Required	Req. if AT2=1 [a]
YM	Req. if AT2=1 [a]	Required	Facility option	Full set	State option	Required	State option	Required	Req. if AT2=1 [a]
Q, QO	Req. if AT2=1 [a]	Required	Facility option	HCFA quarterly plus items at State option	State option	State option	State option	State option	Req. if AT2=1 [a]
QM	Req. if AT2=1 [a]	Required	Facility option	Full set	State option	Required	State option	State option	Req. if AT2=1 [a]
D	Req. if AT2=1 [a]	Required	AB1 and AB2 required if AA8a = 8; otherwise facility option	A6, R3, and R4 only	State option	Inactive	Inactive	Inactive	Req. if AT2=1 [a]
R	Req. if AT2=1 [a]	Required	Facility option	A4a, A4b, A6 only	State option	Inactive	Inactive	Inactive	Req. if AT2=1 [a]
OM	Req. if AT2=1 [a]	Required	Facility option	Full set	State option	Required	State option	Inactive	Req. if AT2=1 [a]
O, OO	Req. if AT2=1 [a]	Required	Inactive	State option	State option	State option	State option	State option	Req. if AT2=1 [a]
X	Req. if AT2=2	Blank	Blank	Blank	Blank	Blank	Blank	Blank	Req. if AT2 = 2

[a] Blank if AT2 = space; this Record Type not allowed if AT2 = 2

FIELD BY FIELD SPECIFICATIONS

Detailed field by field specifications are provided for MDS data records (including assessments, discharge tracking forms, reentry tracing forms, record modification request, and record inactivation requests) in the files D_DT110A.PDF (pp 1-80), D_DT110B.PDF (pp 81-160), and D_DT110C.PDF (pp 161-217). Summary (abbreviated) field by field specifications for data records are provided in the file D_SM110.PDF. Detailed and summary field by field specifications for header records are given in H_DT110.PDF and H_SM110.PDF, respectively. Detailed and summary field by field specifications for trailer records are given in T_DT110.PDF and T_SM110.PDF, respectively.

In the field by field data specifications, there is a separate entry for each field in the record layout. Entries (fields) are separated by dotted lines. Additional entries are occasionally used to allow information to be provided about groups of fields. These additional entries all have a "Type" of "GRP LABEL" (group label). In the detailed data record specifications (D_DT110.PDF), the first entry, "RECORD CONTROL SECTION", is an entry with information for a group of fields (see page 5). The second entry, "RECORD ID", is the first actual field in the layout (see page 5). Now consider the different types of information given for each entry.

ITEM IDENTIFIER/DESCRIPTION. The "Item Identifier/Description" column gives the standard label (e.g., "REC_ID") for the field and a short verbal description (e.g., "RECORD ID").

LEN. The "Len" column gives the length of the field in characters (bytes).

START. The "Start" column is the starting position for the field in the data record.

END. The "End" column is the ending position for the field in the data record.

SPECIFICATIONS. The "Specifications" column gives a variety of information concerning the data requirements for the field. If a specification item in this column is tagged with an asterisk (*), then failure to comply with that specification will result *in a FATAL ERROR and the MDS record will be REJECTED* by the State. If a specification is not tagged with an asterisk (*), then failure to comply will result in a warning (non-fatal error) and the record will still be accepted by the State.

ACTIVE ON RECTYPE. The "Active on RECTYPE" section lists all RECTYPEs for which the field is normally active. When a field is active, then the value for the field is required to conform to specified range, format, and consistency requirements.

INACTIVE ON RECTYPE. The "Inactive on RECTYPE" section lists all RECTYPEs for which the field is inactive. An inactive field is not validated for formatting, range, or consistency upon submission to the State, and the value for the field is not stored in the State database. The inactive field is simply a placeholder and any value is acceptable. It is recommended (but not required) that inactive fields be ampersand (&) filled. This recommendation allows ease of trouble shooting problems when a field has inappropriately been designated as inactive.

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*BLANK ON RECTYPE. The "*Blank on RECTYPE" section lists all RECTYPEs for which the field MUST be BLANK. Note the asterisk here. Failure to comply will result *in a FATAL error and record REJECTION*. At present, BLANK ON RECTYPE is only used for RECTYPE X (record inactivation request).

OPTIONALLY ACTIVE. Notice that there is usually a gap between the "*Blank on RECTYPE" and "Picture" sections. For some fields, a specification will appear here indicating that the field is optionally active.

FAC. OPTION ON RECTYPE. Fields in MDS Sections AB and AC can be active on selected RECTYPEs by facility option (see the specifications for Sections AB or AC). When a field can optionally be made active by a facility, then a "Fac. Option on RECTYPE" entry will occur in the specifications column, and this entry will list the RECTYPEs allowing facility option. Sections AB and AC are from the "Background (Facesheet) Information at Admission". When a facility elects to optionally submit Facesheet information, then the fields are considered to be active and must conform to the range, format, and consistency specifications for the fields.

STATE OPTION ON RECTYPE. Several fields throughout the MDS can be made active on selected RECTYPEs (Q, QO, O, and OO) by State option. When a field can optionally be made active by the State, then a "State Option on RECTYPE" entry will occur in the specifications column, and this entry will list the RECTYPEs allowing State option. When a State elects to optionally require additional fields on a RECTYPE, then the fields are considered to be active and must conform to the range, format, and consistency specifications for the fields. You should contact your State to determine if the State has optionally required additional fields on different record types.

PICTURE. The "Picture" section provides basic format information for the field. A picture of "X" indicates a single alphanumeric character, while "XX" or "X(2)" indicates two alphanumeric characters. A picture of "YYYYMMDD" is used for date fields indicating year (including century), month, and then day format.

TYPE. The "Type" section gives the type of data for each field. Types are CODE, COUNT, TEXT, DATE, CHECKLIST, and GRP LABEL. For active CHECKLIST fields, a blank (space) is entered if the item is skipped because of a skip pattern on the MDS form. For example, if the resident is comatose (B1 = 1), then items B2a through F3d are to be skipped. In this case, the CHECKLIST at B3a through B3e is skipped and a blank should be entered in each of these fields. If a CHECKLIST field is active and not skipped, then a 1 (one) is entered if the field was checked on the MDS form; a 0 (zero) is entered if the field was not checked (blank) on the form; and a - (dash) is entered if the response is "cannot determine" (a circled dash or NA for "Not Applicable" was written on the MDS form).

*RANGE IF ACTIVE. The "*Range if Active" section lists the permissible values for an active field. The asterisk in the label indicates that range errors are FATAL with Version 1.10. If the active field does not have a value listed in the range, then *a FATAL error will occur and the MDS record will be REJECTED*. The following conventions are used in the range list. A value of a single space is indicated by "sp"; a value of two spaces, by "sp(2)"; a value of three spaces, by "sp(3)"; etc. A value of a single

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dash is indicated by "-"; a value of two dashes by "-(2)"; etc. Dashes are used to indicate that the value for a field is unknown, and this will usually correspond to a circled dash or "NA" (not applicable) appearing on the MDS form.

FORMAT INFO. The "Format Info" section indicates additional specifications for the required formatting of a value for an active field. Examples are requirements that text entries be upper case and left justified, and that numeric (count) entries be right justified and leading zero filled. If a specification listed in Format Info is preceded by an asterisk (*), then failure to comply with that specification is ***a FATAL error that will result in record REJECTION***. For example, the Format Info for some numeric (count) entries includes the specification:

   "*Right justified and leading zero filled; no spaces".

If the value for an active field does not comply with such an asterisk-tagged specification, then ***a FATAL error will occur***.   If a Format Info specification is not tagged with an asterisk (*), then failure to comply will result in a warning (non-fatal error) and the record will still be accepted by the State.

CONSISTENCY IF ACTIVE. Some pairs of fields or groups of fields must have consistent values. The "Consistency if Active" section indicates such consistency specifications for an active field.   If a consistency specification is preceded by an asterisk (*), then failure to comply with that specification is ***a FATAL error that will result in record REJECTION***. For example, the consistency requirements for field B2a includes the specification:

  " *1. Value must be blank if B1 = 1; value must be 0 (zero), 1, or - if B1 not = 1."

If the value for an active field does not comply with such an asterisk-tagged specification, ***then a FATAL error will occur***.   If a consistency specification is not tagged with an asterisk (*), then failure to comply will result in a warning (non-fatal error) and the record will still be accepted by the State.

There are required consistencies among the various dates within the MDS record. The requirements for date consistency have been listed for the relevant date fields under "CONSISTENCY IF ACTIVE". An overview of the relationships among dates is depicted in "Required Consistency for the Dates in the MDS Record" (a later section of this document).

There are also required consistencies between MDS records for a resident. These consistencies are detailed in "Required Sequencing/Timing of MDS 2.0 Records" (a later section of this document).

ITEM NAMING CONVENTION FOR THE MDS 2.0

Some confusion has occurred for items that are present in row-by-column tabular form on the MDS 2.0. Consider E4, Behavioral Symptoms. The following table appears on the form:

E4. Behavioral Symptoms

      (A) Behavioral symptom frequency
      (B) Behavioral symptom alterability

	A	B
a. Wandering		
b. Verbally abusive beh.		

With regard to such tables, the HCFA adopted standards for naming the individual MDS 2.0 items is to list the item (E4) followed by the row (a) and then the Column (A). Thus, the upper left cell in the table is E4aA, the upper right cell is E4aB, the lower left cell is E4bA, and the lower right cell is E4bB. Note that the HCFA naming standards also maintain the case of the row and column identified--i.e., "a" for row a and "A" for column A.

To reiterate, the standard naming convention for row-by-column tabled items places the row label before the column label. This convention is to be consistently used for all items involving tables on the MDS 2.0. This includes E4, G1, G4, and P1b. It is the intention that this convention be used in RAP analysis, in RUGs classification, in Quality Indicator analysis, and for all other references to items on the MDS 2.0.

Please note that this naming convention has been correctly applied in the RAP definitions included in the State Operations Manual published in May 1995.

REQUIRED CONSISTENCY FOR DATES IN THE MDS 2.0 RECORD

There are 11 different dates that can be contained in an MDS record. There are requirements both for the sequencing of these dates and for the span of days between dates. Each of these topics is considered below. When any of the 11 dates in an MDS record is recorded or data entered, then that date should be less than or equal to the current date with one exception. That exception involves the assessment reference date (A3a). The assessment reference date (last day of the MDS observation period) may be recorded or data entered as a future date if the MDS observation period has not been completed but is expected to be completed on a specific date. Note that, by the time the MDS record is actually submitted, the assessment reference date must be less than or equal to the current date. The State MDS system will validate all dates in the MDS record and if any date is later than the validation date, ***then a fatal error will occur and the record will be rejected***.

SEQUENCING OF DATES IN THE MDS 2.0 RECORD

Table 6 presents the required date sequencing relationships for dates within an MDS record. For each of the 11 MDS dates, this table details which other dates (that are present in the record) must be "earlier than" or must be "earlier than or the same as". If any of the relationships depicted in Table 6 is violated, then *a fatal error will occur and the record will be rejected*. For example, if AA3 (birthdate) is later than AB1 (admission date), then the requirement that AA3 be earlier or the same as AB1 is violated. Such a date sequencing error indicates serious problems and the record will be rejected.

Note that in versions of the specifications prior to 1.10, date sequencing specifications indicated whether other dates must be "later than" or "later than or the same as", in addition to "earlier than" or "earlier than or the same as". For example, in Version 1.03, AA3 was listed as "earlier than or the same as" AB1, and AB1 was also listed as "later than or the same as" AA3. Such redundancy has been eliminated in Version 1.10 by dropping the entries for "later than" and "later than or the same as".

TABLE 6
SEQUENCING OF DATES PRESENT IN AN MDS RECORD

DATE FIELD/DESCRIPTION		SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE MDS RECORD	
		ROW DATE IS EARLIER THAN	ROW DATE IS EARLIER THAN OR SAME AS
AA3	Birthdate		AB1, A4a, P_REC_DT, AB11, A3a, R2b, VB2, VB4, R4, AT6
AB1	Date of Entry		A4a, P_REC_DT, AB11, A3a, R2b, VB2, VB4, R4, AT6
A4a	Date of Reentry		A3a, R2b, VB2, VB4, AT6
P_REC_DT	Previous Asmt. Ref. Date	A3a, R2b, VB2, VB4, AT6	
AB11	Background Completion Date		
A3a	Assessment Reference Date		R2b, VB2, VB4, AT6
R2b	MDS Asmt. Completion Date		VB2, VB4, AT6
VB2	RAP Completion Date		VB4, AT6
VB4	Care Plan Decision Date		AT6
R4	Date of Discharge		AT6
AT6	Attestation Date		

SPANS BETWEEN DATES IN THE MDS 2.0 ASSESSMENT RECORD

The following date span requirements are based upon the required MDS/RAI assessment procedures detailed in "Long Term Care Resident Assessment Instrument User's Manual" for the MDS 2.0.
The maximum spans between dates within an MDS assessment record are most easily understood visually with the 3 flow charts on the following pages. Figure 2 presents the date spans relevant to an admission assessment; Figure 3, the date spans relevant to other comprehensive assessments; and Figure 4, the date spans for non-comprehensive assessments. These figures allow the date span logic in version 1.10 of the data specifications to be simplified (relative to the earlier logic in version 1.03).

With version 1.10, an MDS record is in compliance with the date span requirements if all of the following conditions are true:

1. R2b should be no more than 14 days later than AB1 (if both dates are present in the record).

2. R2b should be no more than 14 days later than A3a (if both are present).

3. VB2 should be no more than 14 days later than AB1 (if both are present).

4. VB2 should be no more than 14 days later than A3a (if both are present).

5. VB4 should be no more than 7 days later than VB2 (if both are present).

If any of these relationships is violated, then the assessment is not in compliance with the required MDS/RAI assessment procedures and a non-fatal error (warning) will be received by the facility. Extenuating circumstances may force the date spans above to be exceeded in some cases. The actual dates should be reported, even if the spans are exceeded. Software developers must allow the facility to report the actual dates.

Figure 2. DATE SPANS FOR AN ADMISSION ASSESSMENT
(Reason for Assessment AA8a = 01)
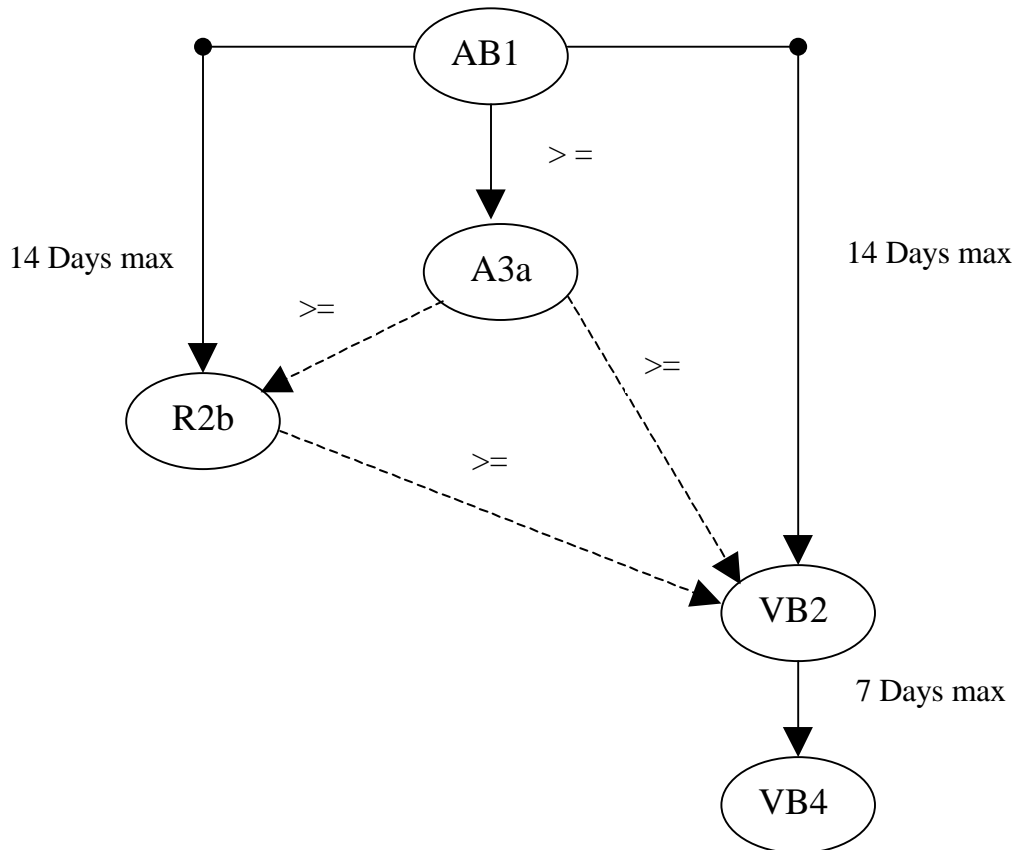
NOTES:
1. In order to be in compliance with the MDS assessment process, dates connected by a solid arrow can be the same date or can differ up to the number of days indicated (at a maximum).
2. The date pointed to by a dashed arrow must be the same as or later than ($>=$) the date at the origin of the arrow. The span between dates connected by a dashed arrow is controlled by parallel solid-arrow relationships.
3.   Extenuating circumstances may force the date spans above to be exceeded in some cases. The actual dates should be reported, even if the spans are exceeded. Software developers must allow the facility to report the actual dates.

Figure 3. DATE SPANS FOR OTHER COMPREHENSIVE ASSESSMENTS:
Annual (AA8a = 02), Significant Change (AA8a = 03),
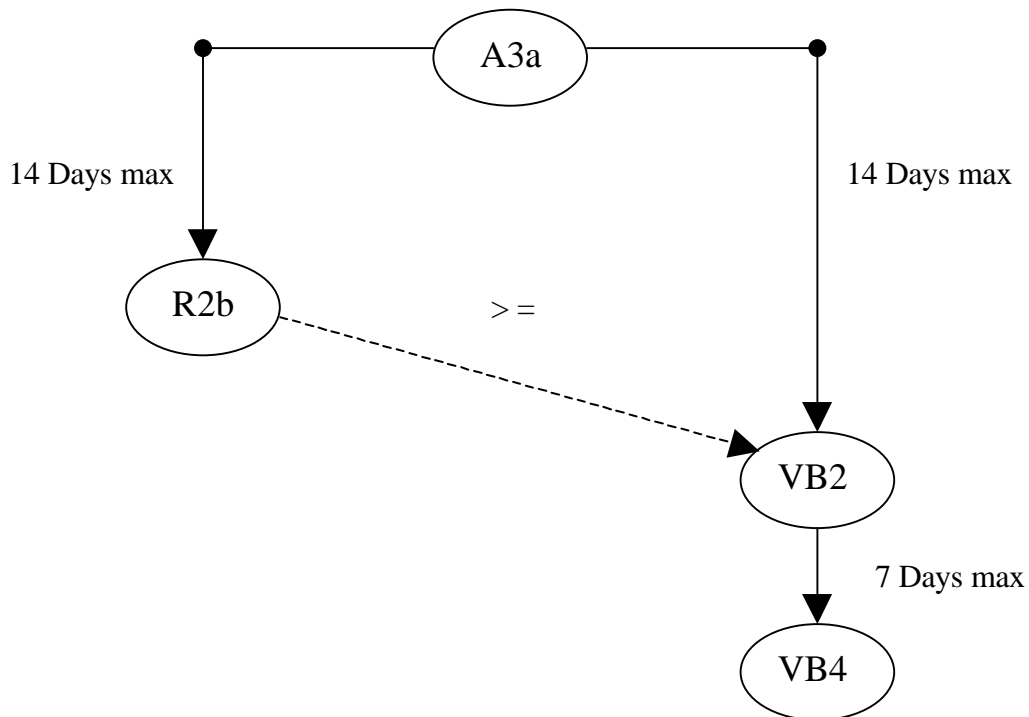**and Significant Correction of Prior Full (AA8a = 04)**

NOTES:
1. In order to be in compliance with the MDS assessment
    process, dates connected by a solid arrow can be the
    same date or can differ up to the number of days
    indicated (at a maximum).
2. Extenuating circumstances may force the date spans
    above to be exceeded in some cases. The actual dates
    should be reported, even if the spans are exceeded.
    Software developers must allow the facility to report the
    actual dates.

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Figure 4. DATE SPANS FOR ASSESSMENTS WHICH ARE NOT COMPREHENSIVE ASSESSMENTS:
Quarterly (AA8a = 05), Significant Correction of Quarterly (AA8a = 10),
and Medicare PPS-Only (AA8a = 00 and AA8b = 1,2,3,4,5,7 or 8)
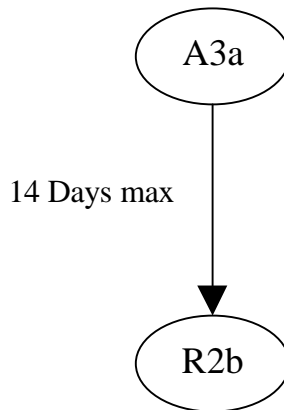
A3a

14 Days max

R2b

NOTES:
1. In order to be in compliance with the MDS assessment process, dates connected by a solid arrow can be the same date or can differ up to the number of days indicated (at a maximum).
2. Extenuating circumstances may force the date spans above to be exceeded in some cases. The actual dates should be reported, even if the spans are exceeded. Software developers must allow the facility to report the actual

EXPECTED SEQUENCING/TIMING BETWEEN MDS 2.0 (1/30/98 UPDATE) RECORDS

The MDS records for each resident will be stored in a longitudinal database at the State level. All of the records for a resident can be scanned in sorted order by date to determine the sequence of records. There are various specifications concerning the sequencing and timing of records for a resident. This section presents those specifications. ***If the submitted records for a resident fail to satisfy these sequence and timing specifications, then non-fatal warnings will occur.*** These warnings will be logged by the State and reported to the facility. Records with timing and sequencing warnings will be accepted and stored in the State MDS database, unless other, fatal errors occur. The State may impose sanctions based on record sequencing and timing irregularities.

The present specifications for record sequencing and timing are based upon Record Type (as defined above) and the reasons for assessment items (AA8a and AA8b) from the MDS. Note that "Other State Required Assessments" (REC_TYPE O and OO) are not standard assessments and these assessments are not addressed in the present sequencing specifications. There are no HCFA specifications concerning such "State specific" records. Any sequencing specifications for "State specific" records will have to be determined and disseminated by the State requiring such records.

The record sequencing and timing specifications presented here do not attempt to present special requirements for Medicare PPS assessments. To insure appropriate payment, Medicare PPS assessments must be performed in a specific order and within specific timeframes. The details of the additional Medicare PPS assessment requirements have been made available in Medicare PPS regulations published by HCFA. The following sequencing and timing requirements only consider Medicare PPS assessments in light of standard HCFA clinical requirements for the MDS, and not in light of additional Medicare PPS requirements for the MDS.

Caution. Some MDS software products do not allow sequence or timing irregularities to occur. These products at times prohibit the user from completing a late assessment or creating an out-of-sequence record. ***This is completely inappropriate.*** If an assessment is performed late, then software products should allow the facility to report the actual dates. If the facility fails to complete and submit an MDS record for a resident, software should not preclude the facility from creating and submitting a subsequent record. A skipped record should not preclude subsequent records.

RECORD SEQUENCING

The sequence of records for a resident should usually conform to certain expectations. For example, a reentry record would not be expected to follow an admission assessment record. If there are exceptions to the following 8 specifications, the facility may have skipped a record or submitted an inappropriate record.

Initial Record. Sequencing specifications 1 and 2 concern the initial record usually submitted for a resident by the facility:

1.   The initial record for a resident in a particular facility should usually conform to the following conditions.

   [LOGIC]:

          The initial record should usually be:
                  TYPE A, AM, or AO
          or   TYPE D (with AA8a = 08)
          or   TYPE OM (with AA8a = 00 and AA8b = 1)

   [DISCUSSION]:

          Normally, the initial record for a resident in a particular facility will be TYPE A, AM, or AO (an admission assessment). Possible exceptions are:
                  (1)   when a new resident is a Medicare Part A recipient under Medicare PPS-- in this case a 5 day (Medicare) assessment (TYPE OM with AA8a = 00 and AA8b = 1) may precede the required admission assessment.
                  (2)   when a new resident is discharged before the admission assessment is complete--in this case the initial record will be TYPE D with AA8a = 08.

2.   When the first TYPE A, AM, or AO record occurs for a resident in a particular facility, then the only TYPES of records (for that resident in that facility) that should usually occur in the set of records preceding the first TYPE A, AM, or AO record are as follows.

   [LOGIC]:

          If the first TYPE A, AM, or AO record is not the first record, then all records preceding that TYPE A, AM, or AO record should usually be:
                  TYPE D (with AA8a = 08)
          or   TYPE R
          or   TYPE OM (with AA8b = 1)
          or   TYPE OM (with AA8b = 5)

   [DISCUSSION]:

          The normal case will be that the initial record for a resident in a particular facility will be TYPE A, AM, or AO. In cases where the initial assessment is not an admission assessment, the first admission assessment record may occur as a later record. In such cases, the records that can usually precede the first TYPE A, AM, or AO record are a discharge before the admission assessment is complete (TYPE D with AA8a = 08), a

reentry record (TYPE R) following such a discharge, a Medicare 5 day assessment (TYPE OM with AA8b = 1), or a Medicare readmission assessment (TYPE OM with AA8b = 5).

Record Following an Assessment Record. Sequencing specifications 3 and 4 concern the records that usually follow an assessment record.

3.　　　　When an assessment record (admission assessment, annual assessment, significant change assessment, significant correction assessment, quarterly assessment, or special Medicare assessment) occurs, then the subsequent record should usually conform to the following conditions:

　　　　[LOGIC]:

　　　　　　IF previous record = TYPE A, AM, AO, Y, YM, YO, Q, QM, QO, or OM then the following TYPEs are usually expected for the subsequent record:

	TYPE Y
or	TYPE YM
or	TYPE YO
or	TYPE Q
or	TYPE QM
or	TYPE QO
or	TYPE OM
or	TYPE D (with AA8a = 06)
or	TYPE D (with AA8a = 07).

　　　　[DISCUSSION]:

　　　　　　When an assessment record occurs, then the next record will usually be any record type except a reentry (TYPE R), a discharge prior to completing an admission assessment (TYPE D with AA8a = 8), or an admission assessment (TYPE A, AM, or AO).

4.　　　　When a Medicare 5 day or Medicare readmission assessment occurs, then sequencing specification 3 above is in effect, but the subsequent record can also be an admission assessment (or discharge prior to completion of the admission assessment) under certain circumstances.

　　　　[LOGIC]:

　　　　　　IF previous record = TYPE OM (with AA8b = 1 or 5) and if one of the following additional two conditions is met:
　　　　　　　　(1) there has been no prior TYPE A, AM or AO record for that resident
　　　　　　　　(2) there has been no TYPE A, AM, or AO record since the last TYPE D (with AA8a = 6) has occurred for that resident,
　　　　　　then the following TYPES are also expected to occur:

	TYPE A
or	TYPE AM

---

or	TYPE AO
or	TYPE D (with AA8a = 8).

[DISCUSSION]:

When an admission assessment is due, then a Medicare 5-day assessment, Medicare readmission assessment, or discharge prior to completing the admission assessment can precede completion of the admission assessment.

Record Following a Discharge. Sequencing specifications 5, 6, and 7 concern the records that can usually follow a discharge record.

5.   If a discharge record with AA8a = 6 occurs, then the resident has been discharged with no expectation of return. This is equivalent to a "close-out discharge". If a closeout discharge occurs and then the resident unexpectedly returns to the facility, the resident should be treated as if he/she is a completely new resident.

[LOGIC]:

If the previous record = TYPE D (with AA8a = 6) then the following types are expected for the subsequent record:

	TYPE A
or	TYPE AM
or	TYPE AO
or	TYPE D (with AA8a = 8)
or	TYPE OM (with AA8b = 1)
or	TYPE OM (with AA8b = 5)

[DISCUSSION]:

Normally, the next record after a closeout discharge will be TYPE A, AM or AO (an admission assessment). Exceptions involve cases in which a new admission assessment is in progress:

(1)   A resident may return as a Medicare PPS recipient--in this case the next record can be a Medicare 5 day assessment (TYPE OM with AA8b = 1) or a Medicare readmission assessment (TYPE OM with AA8b = 5). These "short-term" assessments can be completed before a normal admission assessment.

(2)   A returning resident can be discharged before the admission assessment is complete--in this case the next record could be TYPE D with AA8a = 8.

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6.   If a discharge record with AA8a = 7 occurs, then the resident has been "temporarily" discharged. In this case a reentry or closeout discharge would be expected next.

   [LOGIC]:

   If the previous record = TYPE D (with AA8a = 7) then the following types are usually expected for the subsequent record:
   TYPE R
   or   TYPE D (with AA8a = 6).

   [DISCUSSION]:

   Exceptions can occur. Consider that a "temporary" discharge occurs, with the resident not returning for a year. The facility is not necessarily expected to file a "close-out" discharge in this case. If the resident returns a long time later (e.g., a year later), an admission assessment could be an appropriate next record for that resident.

7.   If a discharge record with AA8a = 8 occurs, then the resident has been discharged prior to completing the admission assessment process. If the resident later returns to the facility, then a reentry, admission assessment, close-out discharge, discharge prior to completing the admission assessment, Medicare 5 day assessment, or Medicare readmission assessment would be expected next.

   [LOGIC]:

   If the previous record = TYPE D (with AA8a = 8) then the following types are usually expected for the subsequent record:
   TYPE R
   or   TYPE A
   or   TYPE AM
   or   TYPE AO
   or   TYPE D (with AA8a = 6)
   or   TYPE D (with AA8a = 8)
   or   TYPE OM (with AA8b = 1)
   or   TYPE OM (with AA8b = 5)

   [DISCUSSION]:

   Normally, the next record after such a discharge will be an admission assessment, reentry or permanent discharge. Normal exceptions involve cases in which a new admission assessment is in progress:
   (1)   A resident may return as a Medicare PPS recipient--in this case the next record could be a Medicare 5 day assessment (TYPE OM with AA8b = 1) or a Medicare readmission assessment (TYPE OM with AA8b = 5).

---

(2)   A returning resident may again be discharged before the admission assessment is complete--in this case the next record could be TYPE D with AA8a = 8.

Record Following a Reentry. Sequencing specification 8 concerns the records that can follow a reentry record.

8.   If a reentry occurs, then any annual, significant change, significant correction, quarterly, Medicare PPS (TYPE OM), or discharge record (with AA8a = 6 or 7) can usually be expected to follow.

[LOGIC]:

If the previous record = TYPE R then:
A. The following types are expected unconditionally for the subsequent record:

	TYPE Y
or	TYPE YM
or	TYPE YO
or	TYPE Q
or	TYPE QM
or	TYPE QO
or	TYPE OM
or	TYPE D (with AA8a = 06)
or	TYPE D (with AA8a = 07).

B.   If one of the following additional two conditions is met:
(1) there has been no prior TYPE A, AM or AO record for that resident
(2) there has been no TYPE A, AM or AO record since the last TYPE D (with AA8a = 6) has occurred for that resident
then the following TYPES are also expected:

	TYPE A
or	TYPE AM
or	TYPE AO
or	TYPE D (with AA8a = 8).

[DISCUSSION]:

A reentry record usually should not be followed by another reentry (TYPE R). Also the next record cannot usually be an admission assessment (TYPE A, AM, AO) or a discharge prior to completion of the admission assessment (TYPE D with AA8a = 8). Only under specific conditions, would an admission assessment or such a discharge be expected to follow a reentry.

RECORD TIMING

The HCFA minimum requirements for the MDS include provisions that certain types of assessments will be performed periodically. For example, full assessments with RAPs (including admission assessments, annual assessments, significant change assessments, or significant correction assessments) should be performed at least annually. Some type of assessment should be performed at least quarterly (every 3 months). If the following specifications fail to be satisfied, then assessments may not have been completed in timely fashion. Assessments can be performed late for a variety of reasons, some not under the control of the facility. If an assessment is late, the facility should report it as such and submit it.

1. A standard MDS assessment (comprehensive or quarterly) is due every quarter unless the resident is no longer in the facility.

    [LOGIC]:

    >   Every record of Type A, AM, AO, Y, YM, YO, Q, QM, or QO is expected to be followed by a record of Type A, AM, AO, Y, YM, YO, Q, QM, or QO within 92 days if the resident is still in the facility at that time. Date R2b from the previous assessment is expected to be within 92 days of date R2b from the subsequent assessment.

    >   If an assessment is due but not performed because the resident has been discharged from the facility, then the required assessment should be completed as soon as possible after the resident reenters the facility at a later date.

2. A full assessment with RAPs is due every year unless the resident is no longer in the facility.

    [LOGIC]:

    >   Every full assessment with RAPs (type A, AM, AO, Y, YM or YO) is expected to be followed by another full assessment with RAPs (type A, AM, AO, Y, YM or YO) if the resident is still in the facility at that time. Date VB2 from the previous full assessment with RAPs is expected to be within 366 days or less of date VB2 from the subsequent full assessment with RAPs.

    >   If an assessment is due but not performed because the resident has been discharged from the facility, then the required assessment should be completed as soon as possible after the resident reenters the facility at a later date.

SPECIFICATIONS FOR MDS 2.0 (1/30/98 UPDATE) SUBMISSION FILES
FOR SUBMISSION FROM THE NURSING HOME TO THE STATE
(Version 1.10)

DOCUMENTATION FOR DBASE AND ASCII LAYOUT FILES
INCLUDED IN THE MDS 2.0 DATA SPECIFICATIONS

There are six layout files included with Version 1.10 of the MDS 2.0 (1/30/98) data specifications: MDS_D110.DBF and MDS_D110.ASC for MDS data records, MDS_H110.DBF and MDS_H110.ASC for MDS file header records, and MDS_T110.DBF and MDS_T110.ASC for MDS data records. These files may serve as an aid to developers in producing MDS data tables and programs. The content of these files is discussed below.

MDS_D110.DBF, MDS_H110.DBF, and MDS_T110.DBF

The MDS_D110.DBF (data record), MDS_H110.DBF (header record), and MDS_T110.DBF (trailer record) files are DBASE format files which give field by field information for all fields included in an MDS file submitted by the nursing home to the State. These DBASE files include one record for each field and contain the basic structure and selected field requirements (for data, header, and trailer records). The contents of each record in the DBASE files are presented in Table 7. Note that the "Status" fields (Status_A, Status_AM, etc.) are only applicable to the data record layout (MDS_D110.DBF) and these fields will be blank for the header record layout (MDS_H110.DBF) and the trailer record layout (MDS_T110.DBF).

Note that a complete description of all field requirements is given in the "Detail Record Layout" documents for data records (D_DT110A.PDF, D_DT110B.PDF, and D_DT110C.PDF), header records (H_DT110.PDF), and trailer records (T_DT110.PDF).

TABLE 7

DBASE LAYOUT FILES FOR VERSION 1.10

FIELD	DESCRIPTION
LOCATION	Form location or label for the MDS item (e.g., AA1 for resident's first name in Section AA of the form).
DESCRIPT	Description for the MDS item on the form.
LEN	Length of the field for the item in the MDS record layout.
RANGE	Permissible values for the item.
PICTURE	A picture clause for the item's value in the layout (E.g., YYYYMMDD for a date in century, year, month, day, format).
TYPE	Whether the item is a date, a code, a checklist item, etc.
STATUS_A	Coded as "A" if the item is active for Record Type A, "I" if the item is inactive for Record Type A, "B" if blank on Record Type A, "S" if a State optional item on Record Type A, or "F" if a facility optional item on Record Type A.
STATUS_AM	The same codes as STATUS_A but for Record Type AM.
STATUS_AO	The same codes as STATUS_A but for Record Type AO.
STATUS_Y	The same codes as STATUS_A but for Record Type Y.
STATUS_YM	The same codes as STATUS_A but for Record Type YM.
STATUS_YO	The same codes as STATUS_A but for Record Type YO.
STATUS_Q	The same codes as STATUS_A but for Record Type Q.
STATUS_QM	The same codes as STATUS_A but for Record Type QM.
STATUS_QO	The same codes as STATUS_A but for Record Type QO.
STATUS_O	The same codes as STATUS_A but for Record Type O.
STATUS_OM	The same codes as STATUS_A but for Record Type OM.
STATUS_OO	The same codes as STATUS_A but for Record Type OO.
STATUS_D	The same codes as STATUS_A but for Record Type D.
STATUS_R	The same codes as STATUS_A but for Record Type R.
STATUS_X	The same codes as STATUS_A but for Record Type X.

MDS_D110.ASC, MDS_H110.ASC, and MDS_T110.ASC

The MDS_D110.ASC (data record), MDS_H110.ASC (header record), and MDS_T110.ASC (trailer record) files are fixed position ASCII format files which give the same information as the Dbase files above (MDS_D110.DBF, MDS_H110.DBF, and MDS_T110.DBF). The contents of each record in the ASCII files are presented in Table 8. Note that the "Status" fields (Status_A, Status_AM, etc.) are only applicable to the data record layout (MDS_D110.ASC) and these fields will be blank for the header record layout (MDS_H110.ASC) and the trailer record layout (MDS_T110.ASC).

TABLE 8

ASCII LAYOUT FILES FOR VERSION 1.10

CONTENTS	POSITION			DESCRIPTION
	START	END	LENGTH	
LOCATION	1	16	16	Form location or label for item.
DESCRIPT	17	66	50	Description for item.
LEN	67	70	4	Length of the field for item.
RANGE	71	110	40	Permissible values for the item.
PICTURE	111	130	20	Picture clause for item's value.
TYPE	131	140	10	Whether the item is a date, a code, a checklist item, etc.
STATUS_A	141	141	1	Coded as "A" if the item is active, "I" if the item is inactive, "B" if blank, "S" if a State optional item, or "F" if a facility optional item on Record Type A.
STATUS_AM	142	142	1	Same codes as STATUS_A but for Record Type AM.
STATUS_AO	143	143	1	Same codes as STATUS_A but for Record Type AO.
STATUS_Y	144	144	1	Same codes as STATUS_A but for Record Type Y.
STATUS_YM	145	145	1	Same codes as STATUS_A but for Record Type YM.

TABLE 8

ASCII LAYOUT FILES FOR VERSION 1.10

CONTENTS	POSITION			DESCRIPTION
	START	END	LENGTH	
STATUS_YO	146	146	1	Same codes as STATUS_A but for Record Type YO.
STATUS_Q	147	147	1	Same codes as STATUS_A but for Record Type Q.
STATUS_QM	148	148	1	Same codes as STATUS_A but for Record Type QM.
STATUS_QO	149	149	1	Same codes as STATUS_A but for Record Type QO.
STATUS_O	150	150	1	Same codes as STATUS_A but for Record Type O.
STATUS_OM	151	151	1	Same codes as STATUS_A but for Record Type OM.
STATUS_OO	152	152	1	Same codes as STATUS_A but for Record Type OO.
STATUS_D	153	153	1	Same codes as STATUS_A but for Record Type D.
STATUS_R	154	154	1	Same codes as STATUS_A but for Record Type R.
STATUS_X	155	155	1	Same codes as STATUS_A but for Record Type X.

DOCUMENTS AVAILABLE WITH VERSION 1.10

Most of the documents available with version 1.10 are Adobe Acrobat files with a "PDF" extension. You must have the Adobe Acrobat reader to view and print these files. The Adobe Acrobat reader can be downloaded and distributed for free and is available from many sites on the Internet including the following:

> http://www.adobe.com

The following documents are available with Version 1.10:

DOCUMENT   DESCRIPTION

SpDoc110.pdf   "Data Specifications for the MDS 2.0 (1/30/98 Update): Version 1.10"

                      General documentation for Version 1.10 concerning MDS 2.0 correction
                      policy, record locking, submission files and submission timing, record
                      layouts, item names, record types, date consistency, record sequencing
                      and timing, and documents available. (45 pages)

CORPL110.pdf   "MDS Correction Policy to Be Implemented With Version 1.10 of the Standard
                      Data Specifications for the MDS 2.0"

                      Brief overview of the new MDS correction policy to be implemented
                      nationally in April 2000 with Version 1.10 of the data specifications. (5
                      pages)

                      Note: A detailed "MDS Correction Policy Provider Manual" will be
                      completed and posted on the HCFA world wide web site in the near
                      future. This manual will present detailed description of the new
                      Correction Policy, provider instructions for implementing that policy, and
                      item-by-item instructions for the Correction Request Form.

PRVMN105.pdf   "MDS Correction Policy Provider Manual, Version 1.0" for use in the
                      State of Washington Pilot Project.

                      This is the Correction Policy Provider Manual for use in the Washington
                      Correction Policy Pilot Project. It is anticipated to be quite similar to that
                      which will be used for nation implementation in April 2000. This
                      Provider Manual presents revised MDS policies implemented in the
                      Washington Pilot Project. Revised polices include new procedures for
                      correcting MDS records, revised locking of MDS records, and revised
                      submission timing for MDS records. The manual provides detailed
                      instructions for correcting MDS records and item-by-item instructions for
                      the MDS 2.0 Correction Request Form. (44 pages)

CFRM105B.pdf   "Correction Request Form for the Washington Pilot Project"

                      This is the Correction Request Form to be used with the new MDS
                      correction policy in the Washington Correction Policy Pilot Project. (1

<u>DOCUMENT</u>   <u>DESCRIPTION</u>

        page)

Note: A different version of the Correction Request Form will be published for national implementation of the new MDS Correction Policy, anticipated in April 2000. The national version of the form is anticipated to contain exactly the same data items in the same order as the Washington Pilot form (CFRM105B.PDF). The only changes expected are correction of one spelling error ("reentry" instead of "rentry") and addition of form attestation language (where the box labeled "Attestation text here" appears on the Washington Pilot form).

Ch103_10.pdf   "Changes with Version 1.10 of the MDS 2.0 Data Specifications"

        Summary of the changes made with Version 1.10 (relative to Version 1.03) of the data specifications (17 pages).

Ch105_10.pdf   "Changes with Version 1.10 of the MDS 2.0 Data Specifications"

        Summary of the changes made with Version 1.10 (relative to Version 1.05) of the data specifications (6 pages).

D_Dt110A.pdf   "Data Record Layout for Submission from the Nursing Home to the State" Pages 1 to 80 (part 1 of 3)

        First part of a detailed field by field description of the MDS data record for a submission file, including field length, type, picture and other formatting information; range and consistency requirements; field status (active, inactive, blank, etc.) on different Record Types; and other information. (80 pages)

D_Dt110B.pdf   "Data Record Layout for Submission from the Nursing Home to the State" Pages 81 to 160 (part 2 of 3)

        Second part of a detailed field by field description of the MDS data record for a submission file, including field length, type, picture and other formatting information; range and consistency requirements; field status (active, inactive, blank, etc.) on different Record Types; and other information. (80 pages)

D_Dt110C.pdf   "Data Record Layout for Submission from the Nursing Home to the State" Pages 161 to 217 (part 3 of 3)

DOCUMENT	DESCRIPTION

Third part of a detailed field by field description of the MDS data record for a submission file, including field length, type, picture and other formatting information; range and consistency requirements; field status (active, inactive, blank, etc.) on different Record Types; and other information. (62 pages)

D_Sm110.pdf

"Abbreviated Data Record Layout for Submission from the Nursing Home to the State"

An abbreviated (summary) field by field description of the data record for a submission file, including field length, type, picture; range; and field status (active, inactive, blank, etc.) on different Record Types.   (36 pages)

H_Dt110.pdf

"Header Record Layout for Submission from the Nursing Home to the State"

A detailed field by field description of the header record for a submission file, including field length, type, picture and other formatting information; range and consistency requirements; and other information. (7 pages)

H_Sm110.pdf

"Abbreviated Header Record Layout for Submission from the Nursing Home to the State"

An abbreviated (summary) field by field description of the header record for a submission file, including field length, type, picture, and range.   (2 pages)

T_Dt110.pdf

"Trailer Record Layout for Submission from the Nursing Home to the State"

A detailed field by field description of the trailer record for a submission file, including field length, type, picture and other formatting information; range and consistency requirements; and other information. (1 page)

T_Sm110.pdf

"Abbreviated Trailer Record Layout for Submission from the Nursing Home to the State"

An abbreviated (summary) field by field description of the trailer record for a submission file, including field length, type, picture, and range.   (1 page)

MDS_D110.dbf

A DBASE format file which gives field by field layout information for all fields in the DATA record layout used for submission of MDS data from the

DOCUMENT	DESCRIPTION
	nursing home to the state.
MDS_H110.dbf	A DBASE format file which gives field by field layout information for all fields in the HEADER record layout used for submission of MDS data from the nursing home to the state.
MDS_T110.dbf	A DBASE format file which gives field by field layout information for all fields in the TRAILER record layout used for submission of MDS data from the nursing home to the state.
MDS_D110.asc	An ASCII format file which gives field by field layout information for all fields in the DATA record layout used for submission of MDS data from the nursing home to the state.
MDS_H110.asc	An ASCII format file which gives field by field layout information for all fields in the HEADER record layout used for submission of MDS data from the nursing home to the state.
MDS_T110.asc	An ASCII format file which gives field by field layout information for all fields in the TRAILER record layout used for submission of MDS data from the nursing home to the state.

RAP SPECIFICATIONS

Note that no changes have been made to the RAP specifications documents with Version 1.10. The current RAP documents are as follows:

RAP101.TXT   An information file (ASCII) describing the RAP documents available.

RAP101.PRG   An ASCII file giving standard code (logic) for calculating MDS 2.0 RAP triggers.

RAP101.ASC   An ASCII format MDS 2.0 test database with known RAP values. This database was created to aid testing of software incorporating MDS 2.0 RAP calculations.

These 3 files are contained in a ZIP file (RAP101.ZIP) available on the HCFA MDS World Wide Web site for downloading. The address for the HCFA MDS web site is as follows.

http://www.hcfa.gov/medicare/hsqb/mds20/