MDS 3.0 Vendor Questions and Answers 1 – 15 Consolidated

October 21, 2014

ID	Topic	Question	Answer
20141021-001	A - Policy	A third-party, private insurance company requires that facilities complete and submit an assessment to them for reimbursement. Since the beneficiary does not have a Health Insurance Claim Number (HICN) to enter into Item A0600B, the new edit for this item is causing a problem with our software in that the facility cannot "lock" the assessment in order to generate a RUG. What can a vendor do to assist the facility in order to generate a RUG to send to the third-party insurance company?	Edit (-3571) for Item A0600B states: "If this is a PPS assessment (A0310B= [01,02,03,04,05,06,07]), then the Medicare or comparable railroad insurance number (A0600B) must be present (not [^]). Thus, the submission will be rejected if this is a PPS assessment and A0600B is equal to [^]." In effect, if an assessment is coded as a PPS assessment, it will fail edit -3571 if the HICN or comparable Railroad Insurance number is not present (left blank) in Item A0600B. Rationale: Assessments that are being completed for third party billing must NOT be submitted to the QIES ASAP system. Marking assessments as a PPS assessment when it is not for a Medicare part A Stay does not follow RAI coding instructions. Submitting assessments marked as PPS to CMS when a facility is not seeking payment for a Medicare part A stay, is a violation of HIPAA's minimum necessary standard. Vendors should work with their providers to meet their needs. How these needs are met are between the provider and the vendor, i.e., a business arrangement. A vendor is permitted (and encouraged) to add additional functionality that the free, CMS provided software, jRAVEN, does not provide. An example of a possible vendor solution to the question above: The vendor may choose to not enforce this edit until the RUG has been generated since the assessment is for third-party insurance purposes and would not be submitted to CMS.
20110126-002	A - Policy	Will anything be done to verify that the therapy dates are correct when flagging A0310C as an SOT or EOT OMRA? For example	CMS will consider edits to the OMRAs. However, due to midnight rule, leaves of absences, and other issues, some edits would be too firm and may prevent a provider from completing and submitting an accurate and required assessment.

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		1- that there are start dates if an SOT OMRA is specified 2- that there is at least one end date and that all therapies have end dates and not dashes if an EOT OMRA is specified. 3- for an SOT OMRA that the earliest therapy start date is no more than 7 days prior to the ARD What happens if this information is incorrect and the assessment is accepted as is? Note that the AI code generated uses A0310C and does not verify the dates. This makes the logic for billing unusable.	The provider is responsible for ensuring that assessment data is accurate. When a provider enters inaccurate information, the provider must determine what should be done to rectify the assessment. In some instances a significant correction assessment should be completed, a modification of the existing assessment or an inactivation of the assessment. CMS specifications for the MDS 3.0 meet OBRA and SNF PPS assessment requirements; they don't meet billing needs. A provider must ensure that claims are accurate. For example, if a provider completes a late SNF PPS assessment, the provider must follow the late assessment policy, which is bill default for the appropriate number of days. Keep in mind that assignment of a RUG-IV/HIPPS does not mean that SNF coverage requirements have been met – the provider must ensure all requirements are met, not the assessment tool.

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20110126-003	A - Policy	**INTERPRETING THE SUB-REQ FIELD** With the implementation of MDS 3.0, our organization interpreted the SUB-REQ field to be the deciding factor on whether a record should be included in the EDT file. That interpretation was based on the actual MDS description of the SUB-REQ field which states: 1. Neither federal nor state required submission, 2. State but not federal required submission 3. Federal required submission. Our software was designed so that if a MDS has a SUB-REQ = 2 or 3, then the record is included in the EDT file and is transmitted to CMS. If the SUB-REQ field = 1, then the MDS does not get included in the EDT file. We do not allow any other way to remove records from the EDT file. **ACTUAL DEFINITION** The actual RAI manual definition of the SUB-REQ field differs from the MDS descriptions. That definition states the value is based on whether the resident is in a Medicare or Medicaid certified bed. All of our beds are certified, so based on the RAI manual, all of our MDS's must have SUB-REQ = 3.	The requirement for SUB-REQ has not changed with MDS 3.0. With MDS 3.0 CMS created an item specific for the sub-req. The sub-req is determined by the type of unit the resident is on and which entities have the authority to collect the assessment data. It is not at all related to payment type. Page A-6, states: Code 1, when the unit the resident is on, is not Medicare or Medicaid certified unit AND the State does not have the authority to collect MDS information for residents on this unit Code 2, when the unit the resident is on, is not Medicare or Medicaid certified AND the state does have the authority to collect MDS information for residents on this unit Code 3, when the unit the resident is on is Medicare and/or Medicaid certified. CMS requires that assessments required to meet OBRA and/or SNF PPS requirements are submitted (sub-req 3) and when a State has the authority to collect but unit is not certified (sub-req 2). Thus, CMS specifications meet only these requirements. A provider may choose to complete an assessment for other purposes, such as HMO billing. However, if the provider completed item A0310 accurately, which they should,– A0310A = 99, A0310B = 99, A0310C = 0, and A0310F = 99, a CMS item set would not be generated. Thus this not an assessment to submit.
20101220-001	A - Policy	We (vendor) have a central database and we must use automated scripting; what are you suggesting we do to replace that?	CMS is not suggesting an alternative; simply advising that the system was not designed for automated scripting and we must insist that vendors stop using it.
20101220-004	A - Policy	Can additional lines be added in Z0400 for staff signatures?	Yes, additional signature lines may be added.
20100926-004	A - Policy	In 2003 CMS required nursing homes to backup their local database to safeguard their MDS 2.0 information. Is this required for MDS 3.0?	Yes. Nursing Homes should back up their local databases. jRAVEN has a backup utility for the provider to use to back up their database. Other vendor software should also have a method of backing up the data.
20100926-002	A - Policy	When a facility sends in a combined assessment: A0310A set to 01 (Admission), or 02 (Quarterly), or 03 (Annual), or 04 (Significant Change in Status), or 05	1. If a record had A0310A=01, 02, 03, 04, 05, 06 and a discharge (A0310F=10, 11), it would qualify both as a regular OBRA assessment and as a discharge. Note that the assessment reference date must equal the

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		(Significant Correction to prior comprehensive assessment), or 06 (Significant Correction to prior Quarterly assessment) AND A0310F set to 10 (Discharge - return not anticipated), or 11 (Discharge - return anticipated) 1. How is this assessment viewed? -- As a discharge? As a regular assessment? Or as both? 2. When a combined assessment is submitted, that resident is discharged. So when/if the resident returns, would the facility submit an entire new assessment on that resident OR would the facility retrieve the combined assessment that contained the discharge and update and re-submit that one (i.e. remove the A0310F code of discharge and then continue on with the full assessment with a '99' in the A0310F field)? If combined assessment - reused… 2a. If the combined assessment is re-used is there a time limit on when it can be re-used? 2b. Also if combined assessment re-used, how does that affect the ASSESSMENT_ID field? Is a new ID assigned to it? Or does the ASSESSMENT_ID remain the same?	discharge date or the combination is not valid and will be rejected. 2. If an assessment has a reference date on or before the date of a temporary discharge with the resident later returning to the facility, then that assessment and the existing OBRA assessment schedule remain in effect if the following 2 conditions are satisfied: 1. The discharge was with return anticipated (A0310F = 12) and the resident returns within 30 days of discharge. 2. A significant change in status has NOT occurred. If the discharge was with return not anticipated (A0310F = 11), then a new admission assessment is due after the resident returns and the OBRA assessment schedule restarts. If the resident was discharged with return anticipated but has been out of the facility for more than 30 days, then a new admission assessment is due after the resident returns and the OBRA assessment schedule restarts. If the discharge was with return anticipated and the resident returns within 30 days with a significant change in status, then a significant change in status assessment is due after return and the existing OBRA assessment schedule continues. 2b. Each submitted record is assigned a unique ASSESSMENT_ID value.
20100720-035	A - Policy	The short stay documentation refers to previous assessments. In the text “A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been completed. The PPS 5-day or readmission/return assessment may be completed alone or combined with the Start of Therapy OMRA” it seems like the documentation is telling us to look at previously completed assessments but the CPP code and the DLL cannot do that since it is fed only the current assessment. Can you provide some clarity on this point? Do we ignore that portion of the logic or do we need to find the previous assessments?	The second condition for an assessment to be classified as a Medicare Short Stay Assessment is as follows: "2. A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been completed. The PPS 5-day or readmission/return assessment may be completed alone or combined with the Start of Therapy OMRA." According to Medicare SNF PPS assessment requirements, a stand-alone Start of Therapy OMRA should never be performed before the 5-Day or Readmission/Return assessment for a Medicare stay. If a Start of Therapy OMRA is performed and the 5-Day or

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			Readmission/Return assessment has not yet been performed, then the following Medicare SNF PPS requirements apply: a. That unscheduled Start of Therapy OMRA assessment replaces the scheduled 5-Day or Readmission/Return assessment. A subsequent 5-Day or Readmission/Return assessment is not allowed. b. The assessment should be coded as both a Start of Therapy OMRA and a 5-Day or Readmission/Return assessment. c. All requirements for both the Start of Therapy OMRA and the 5-Day or Readmission/Return assessment must be satisfied. It is the facility's responsibility to insure compliance with these requirements. Any Start of Therapy OMRA assessment that complies with these requirements will automatically satisfy the Medicare Short Stay Assessment condition #2 above. It is not necessary that the standard RUG-IV grouper (DLL or SAS code) actually test the second condition, since it should always be true. Private software vendors, who develop their own RUG-IV classification code, need not test the second condition when classifying a Start of Therapy OMRA assessment as a Medicare Short Stay assessment. However, software vendors may want to alert the facility when a Start of Therapy OMRA precedes the 5-Day or Readmission/Return assessment. The facility would be advised that this is not allowed and the facility must combine the Start of Therapy OMRA assessment with the scheduled 5-Day or Readmission/Return assessment.
20100420-Ad Hoc18	A - Policy	Will CMS offer any guidance in printing rules? Is there any concern by CMS whether or not sections break in the same place, if the same fonts are used, or if an entire section is not printed when it is not actually part of that particular assessment?	CMS has no requirements for printed documentation. When surveyors go out and want to see documentation at a facility, CMS has no particular formatting requirements in that environment. We simply have the requirement that the data has to be available. It is not our call to take on the role of dictating what printed copy should look like.

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20100420-35	A - Policy	Can you please tell us where to get specific information regarding quality measures for MDS 3.0?	Information on the MDS3.0 Quality Measure can be found on the CMS website http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html
20100420-18	A - Policy	I would like to clarify something related to the use of the MDS 3.0 forms. We would like to use the MDS 3.0 PDF forms, as they are formatted, in our software. Would there be any copy write restrictions related to that? Our intent is to simply allow the user to fill out the PDF to complete the MDS. None of the copy written material currently a part of the MDS would be used outside of the PDF form.	You would not be infringing on any copyrights by using our PDF version of the form.
20100225-094	A - Policy	Is there a regulation that assessments must be submitted in order? Example: The resident is discharged for 1 day. The Entry record is submitted on the Entry Date + 14. The Discharge Assessment is submitted later the same day OR submitted 7 days after the Entry record. Since both were submitted within the required submission period, is there an issue with their being submitted out of order?	Records submitted in the same file are sorted by target date prior to processing. Records submitted in separate files on the same day are processed in order of submission date and time. If 2 records have the same target date and are submitted in the same file or in separate files with the "earlier one" submitted prior to the "later one", or if they are submitted in files with different user IDs, then there is a possibility of receiving sequencing warning messages from the submission system.
20100225-084	A - Policy	What is the definition of the start of a therapy regimen? Is it the Initial Eval/Re-eval date or the date that the 1st therapy treatment was given?	Evaluation date.
20100225-053	A - Policy	We see that the MDS form has copyright information at the bottom of some section pages. For example – Section D has "*Copyright © Pfizer Inc. All rights reserved. Reproduced with permission."* Does Copyright information need to appear on entry screens that we develop or only on printed forms?	The copyright needs to appear on all versions of the MDS 3.0 either on screen or on paper.
20100225-005	A - Policy	If a correction needs to be submitted for an MDS assessment that CMS has already accepted, is there a time limit on submitting such correction (i.e., only have X # months to submit corrections for accepted MDS forms)? Same question for rejected assessments - does a hospital need to submit within a certain time frame after an MDS is rejected by CMS?	As of September 21, 2014, the following new edits will be enforced. Records with a target date more than 3 years prior to the submission date will be rejected. Records submitted more than 2 years after the closed date of the facility will be rejected. Records with a target date after the closed date of the facility will be rejected.
20100114-039	A - Policy	We have heard that the 3.0 assessment is meant to be an 'on-line' assessment. Does that mean a printed copy will not be required in the chart? How will signatures be handled?	From section Z in the RAI manual: Nursing homes may use electronic signatures for medical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the nursing home's policy. Nursing homes must have written

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			policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs. Although the use of electronic signatures for the MDS does not require that the entire record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.
20141021-002	E-Specs	If A0100C is blank ^ does the 3606 fire or is the edit contingent on data in A0100C -3806 Consistency Warning If A0200=[1] (the provider is a nursing home), the value submitted for A0100C (State Provider Number) will be compared with the value that is currently in the MDS Submission System database. If the values do not match, a warning will be issued. Note that this edit does not apply to swing-bed providers (A0200=[2]).	The -3606 warning edit always fires. If the value submitted is a caret [^] and the state has a blank (null) for the field in the database, then they match; otherwise the error is issued. The item in error contains A0100C, Current Value and the value in error contains the caret [^], xxxxx, where xxxxx is the state provider number stored in the database.
20141021-003	E-Specs	When ICD-10 is implemented does CMS have a master list of state's prohibited ICD-10 codes?	For both ICD-9 and ICD-10, states are responsible for identifying the prohibited STD and/or HIV ICD codes prohibited by their state and to update the MDS Data Management System (DMS) with these codes.
20141021-004	E-Specs	I believe edit -3535 either has a mistake or worded incorrectly. The edit states it is active in the NC item subsets, but when you read the instructions, it states it is skipping several of the NC subsets such as (03=annual=NC, 04=significant change in status=NC, 05=significant correction to a prior nursing comprehensive).	Your question assumes that the skip pattern for the G0900 items is based upon the ISC (i.e., the G0900 items are completed if the ISC=[NC]), but this assumption is incorrect. If you look at the printable item sets, you'll see the following instruction: **G0900. Functional Rehabilitation Potential** **Complete only if A0310A = 01** The instructions that are printed on the item set state that G0900A and G0900B are completed only if A0310A=[01]. Edit -3535b enforces this instruction. Edit -3535a handles the converse situation where A0310A is equal to a value other than [01]. Since G0900A and G0900B are active only on NC, some of the values listed for A0310A in edit -3535a are not really necessary. For example, if A0310A is equal to [02] (quarterly assessment), then G0900A and G0900B are not active. However, like most skip pattern edits, edits -3535a and -

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			3535b contain the phrase “all active items”. This means that if the referenced item is not active for a particular ISC, then the edit does not apply. Edit -3535a includes the extra values of A0310A so that the edit doesn’t have to be revised if the ISCs for G0900A and/or G0900B change in future versions of the data specs.
20141021-005	E-Specs	I have a situation with a client relating to a SoT and which dates are to be entered in O0400. Our understanding is that the Start of Therapy Dates (items O0400A5, O0400B5 & O0400C5) should be for the current Therapy period being started. Our client continues to enter Start/End Dates related to an earlier reported EOT which conflict with the actual new Start of Therapy date.	Your understanding of the therapy period is incorrect. The incorrect concept is that the therapy start and end dates are only completed for a current period of therapy where any of the therapy disciplines (ST, OT, and/or PT) are being provided. The start and end dates for a discipline are defined in the RAI Manual Chapter 3 as follows: • **Therapy Start Date**—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption (O0450B) on the resident’s EOT OMRA, in cases where the resident discontinued and then resumed therapy. • **Therapy End Date**—Record the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident received skilled therapy treatment. Enter dashes if therapy is ongoing. The dates to be entered are dates for "the most recent therapy regimen (since the most recent entry/reentry)". So the therapy dates for ST could be from two years ago, as long as the resident was not discharged after that. It does not matter that there is a new current regime for another discipline (e.g., OT).
20141021-006	E-Specs	One of our customers is getting an MDS rejected due to a RUG score issue. The MDS is a 5 day / SOT / Discharge – Return Not Anticipated. The Z0100 RUG is RMB and the Z0150 non therapy is LC1. The error they are getting is - 3804: Inconsistent HIPPS code: If A0310C equals 1 or 3, then the first character of Z0100A calculated by the QIES	Starting 10/1/2013, Medicare classification requirements for Medium Rehabilitation were changed. Before that the number of days of therapy requirement was 5 or more days across the disciplines: sum of O0400A4 +O0400B4 + O0400C4. After 10/1/2013, the number of days of therapy requirement changed to 5 distinct calendar days of therapy

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		ASAP System must equal R.	(O0420). While this assessment has 2 days of therapy for each discipline (speech, PT, OT) giving a sum of 6, there were only 3 distinct calendar days of therapy reported in O0420. With only 3 distinct days, the assessment is not classified as Medium Rehab. The fatal error -3804 was reported because this is a Start of Therapy (SOT) OMRA and the normal Medicare classification must be in a Rehab/Extensive or Rehab group. Since the correct classification is not in a Rehab/Extensive or Rehab group, the record cannot be a coded as an SOT OMRA and the record is rejected. When this error occurs the grouper returns “AAA” for the system recalculated RUG. This record cannot be submitted as a Start of Therapy OMRA. To make the record acceptable, change the SOT OMRA indicator (A0310C) to 0. Also the grouper is using the wrong therapy classification type. The grouper parameter sRehabType must = “MCAR3” to apply the correct rehab classification type for Medicare in FY2014. With this correct parameter setting the classification will be below the Rehab groups.
20141021-007	E-Specs	According to the v1.14.1 specifications the “06” or “6” value for A0310B has been removed. The isc_val (v1.14.1) 05-08-2014.csv file still contains ICS combinations for A0310B = 6 1. Will the A0310B=6 combinations be removed from the ISC_VAL set? 2. What further documentation about the effect of removing ’06 – Readmission/Return’ will be provided – either in the form of RAI updates or other specific documentation of Medicare PPS Scheduled assessments and when can Vendors expect that information.	Yes, the ISC_VAL (v1.14.1) 05-08-2014.csv file still contains ICS combinations for A0310B = 6. Columns H and I contain values for A0310B and include the discontinued values ("6" or "06"). The values of "6" (or "06") in the ISC_VAL table will not be removed. These rows of the table were retained to allow the determination of the ISC for older assessments where A0310B can equal "6" (or "06"). For newer assessments where this value is not allowed, these rows can be ignored. No further documentation about the effect of removing the discontinued values ("6" or "06") is anticipated; however, I will have this question posted on the MDS 3.0 Vendor section of the QIES Technical Support Office Website: https://www.qtso.com/vendormds.html .
20141021-008	E-Specs	In the Oct 2014 draft data specs answer 6 - Readmission is removed from X0600B but it is not removed from V0100B. Normally, for Prior assessment information in section X the	A0600B will not be allowed to be equal to 06 on records (new or modified) submitted after the October 1, 2014 release during the September, 2014 downtime.

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		exact answers are pulled from the original MDS so that the ASAP system is able to make a match for a modification or inactivation. Are vendors to convert X0600B = 6 to be =1 after October? Alternatively V0100B has not removed the answer 6? It seems that the answer would be removed consistently.	We believe that the data specs are correct as written with regard to V0100B and X0600B. Records submitted under V1.14 of the data specs must have target dates on or after 10/1/2014. Item V0100B is used to indicate the PPS reason for assessment for the prior PPS assessment, if one exists. The prior PPS assessment could have been submitted under V1.13 of the data specs and could therefore have a value of [06] in A0310B. Item V0100B in the new data specs must therefore allow a value of [06]. However, the situation is different for a modification record where X0600B would be completed. Beginning with V1.12 of the data specs, we allowed a modification record to cross data specs boundaries (i.e., for the modification record to change the target date and to conform to a version of the data specs which is later than the record being modified). While this is allowed, it must be used with caution because items and/or values that are allowed on the two versions may differ. An example of such a situation is where modification record has a target date on or after 10/1/2014 and conforms with V1.14, but the record to be modified has an earlier target date and has A0310B=[06]. In this situation, you have two choices. If, after modification, the target date will still precede 10/1/2014, then you should do the modification under the earlier version of the data specs. If you are modifying the record so that the target date will be changed to a date which is on or after 10/1/2014, then your only choice would be to inactivate the original record and submit a new record under V1.14. Note that this scenario should be quite rare.
20141021-009	E-Specs	It has always been our understanding (based on the MDS 3.0 Provider User's Guide, pg 5-102) that MDS modifications and inactivations are matched by ensuring that X0150, X0200A, X0200C, X0300, x0400, X0500, X0600A, X0600B, X0600C, X0600D, X0600F, X0700A, X0700B, and X0700C values in section X exactly match a previous accepted assessment's corresponding Section A values. We have always assumed	The ASAP system does use target date to locate the original record using item X0700 to determine the target date of the original record. It only uses the date that "matches" the X0600F value and ignores the other two X0700 dates as they should be sent in as blank [^]. It appears from your description that the original record

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		that if any one of those values does not match; the modification would not match with the original assessment in the ASAP system. However, we've come across an interesting scenario where not all of the items in Section X match their corresponding fields in Section A, yet the assessment was accepted into the ASAP system. Specifically, all the values match except X0700C (Correction Entry Date) on the modification does not match A1600 (Entry Date) on the original assessment. The assessment's value for A0310F = 99 which indicates the ARD is the target date for the assessment. In this case, the target date calculated based on Section X fields on the modification does match the target date calculated based on Section A of the original assessment. This seems to indicate that the ASAP system matches modifications / inactivations to their original assessments based on the Target Date instead of requiring an exact match for X0700A, X0700B, and X0700C to their respective corresponding fields in Section A.	was coded as A0310F = 99. Item X0700 has instructions on whether to answer A, B, or C based on the value in X0600F. If you answered X0600F = 99 to match your original A0310F = 99, then you should have only answered X0700A per the item instructions and sent in blanks [^] for X0700B and X0700C.
20141021-010	E-Specs	There seems to be a small inconsistency in the error message displayed in the VUT output For the comparison of A1600 Entry date and A1900 Admit date when A1700 = 1 Specs seem to indicate dates MUST EQUAL, but error message says EQUAL OR GREATER Can you clarify which is correct? Extract of data elements in MDS XML file passed to VUT <A1600>20140901</A1600> <A1700>1</A1700> <A1800>01</A1800> <A1900>20140902</A1900> <A2000>^</A2000> <A2100>^</A2100> <A2200>^</A2200> <A2300>20141001</A2300>	There are not any inconsistencies in the VUT and HTML data specifications for A1600 and A1900. We believe this is an instance where we have a general edit (-3851) as well as specific edits that apply to the same item. The record must pass all edits. This occurs in many of the edits and MDS data specifications. The most common case of general edit and specific edit is on coded values: An example in Section A is for A0200: The general edit is -3676 Values of Code and Checklist Items: Only the coded values listed in the "Item Values" table of the Detailed Data Specifications Report may be submitted for this item. One of the specific edits is -3707 a) If A0200=[2] (if the provider is a swing bed provider), then A0410 (submission requirement) must equal [3] (it cannot equal [1,2]).

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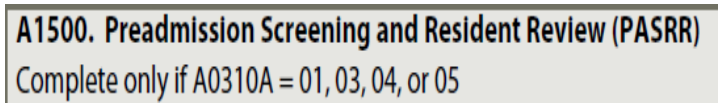
		Error received in VUT for a 10/1/14 MDS with A1700 = 1 <results> <message_number>2</message_number> <error_id>-3851</error_id> <severity>FATAL</severity> <text>Date A1600(09/01/2014) must be the same as or later than date ***A1900***(09/02/2014)</text> <item>A1600</item> <item_value>20140901</item_value> </results> A1600 and A1900 edits as shown in the MDS HTML file specs for 10/1/14 -3860 - If A1700=[1], then A1600 must equal A1900. -3861 - If A1700=[2], then A1600 must be greater than A1900.	b) If A0200=[1] (the provider is a nursing home), then A0410 must equal [2,3]. c) For both nursing homes and swing bed providers, A0410 must not be equal to [1]. The value of A0200 must be one of the listed value values, but it also must obey the specific edits in -3707.
20140107-008	E-Specs	In the recent Errata document (MDS 3.0 data specs errata (v1.13.2) 08-12-2013.pdf) for some of the issues it was mentioned that the Edit check will not be implemented by CMS but software vendors can implement these edits. We are planning to implement this Edit in our software. **The question is: Do we need to consider these edits as *Fatal (or) Warning*?**	It is up to the software developer whether to make the recommended edits warnings or fatal edits. For now, the VUT that is provided by CMS will implement these edits as warnings so that records are not rejected if they do not comply with the recommended edits. However, we anticipate that when these edits are added as "real" edits to the data specs and implemented by ASAP, they will be fatal edits. You may want to implement them as fatal edits now so users won't have to be retrained at a future date.
20140107-009	E-Specs	I am looking for some consistency within the specifications. Example being the way that the files are set up to deal with A1500, A1510 and A1550. Form for A1500.  Says skip if say A0310a=02 There is a record within RLTN_ITM_TXT to deal with this	The edits for A1500, A1510, and A1550 are different from one another. It is true that all three items contain the instruction on the item set "complete only if A0310A=01, 03, 04, or 05". However, the logic for completing the three items is different. Item A1500 is dependent solely upon the value of A0310A. The logic of A1510 depends upon the response to A1500. The logic for A1550 depends upon A0310A plus the resident's age. Since the completion logic for these three items is different, the edits must be different. It is therefore not possible for the specifications to be consistent for these three items. Consistency is applied to all of the specifications when possible.

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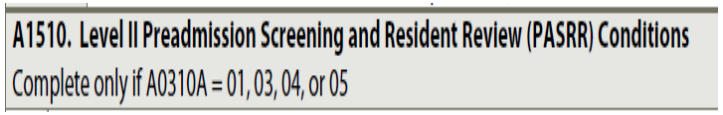
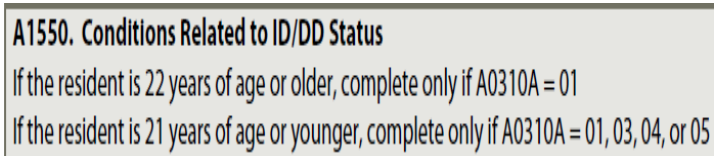
		Form for A1510.  **A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions** Complete only if A0310A = 01, 03, 04, or 05 Form looks to have the same issue. Yet the records in RLTN_ITM_TXT… Set up the relation between A1500 and A1510…rather than anything based on A0310a. Form for A1550  **A1550. Conditions Related to ID/DD Status** If the resident is 22 years of age or older, complete only if A0310A = 01 If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05 In RLTN_ITM_TXT because of its complexity based on age shows… It as a consistency remark…yet in the case of A0310a=02 for my example…it really is a skip. But it is still better than how you are dealing with A1510…at least there is a mention of dependency on A0310a within these checks.	
20140107-007	E-Specs	Question about Edit -3846 in V1.13.2: Consistency between therapy days within types of therapy and distinct days across types of therapy. Item O0420 must conform with the following rules: a) If O0400A4, O0400B4, and O0400C4 are all equal to [-], then O0420 must equal [-]. b) If O0420 is not equal to [-], then both of the following rules apply: ---b1) O0420 must contain a value that is greater than or equal to the largest value in O0400A4, O0400B4, and O0400C4. When determining this value, if any of the items O0400A4, O0400B4, and O0400C4 is coded with [-,^], count the number of	Yes, a user is allowed to enter a dash in O0420 even if O0400A4, O0400B4, and O0400C4 have numeric values.

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		days for that item as zero. ---b2) O0420 must contain a value that is less than or equal to sum of the days in O0400A4, O0400B4, and O0400C4. When computing this sum, if any of the items O0400A4, O0400B4, and O0400C4 is coded with [-,^], count the number of days for that item as zero.. **Are users allowed to enter a [-] for O0420 if any of O0400A4, O0400B4, and O0400C4 have a value other than [-]? The edit does not seem to restrict entry of [-] even though there is a value present for O0400A4, O0400B4, or O0400C4**	
20140107-010	E-Specs	**Version Notes** [V1.13.0]-New edit. This edit replaces Edit -3573 for all records submitted on or after 09/15/2013. This edit differs from Edit -3573 as follows: 1. Item A2200 was removed from the Group A rules. 2. No changes were made to the Group B rules. 3. Group C rules were added and apply only to records where A0310A=[05,06] (significant correction of prior comprehensive or quarterly). If this is for the October 2013 MDS, and this edit is for all records submitted on or after 9/15/2013, does that mean that user will need to have the program prior to the 9/15 date and be using it???	The short question is: yes, the new edit -3851 replaces the old edit -3573 for all records submitted on or after 09/15/2013. Having said that, the functional differences between the new and old edit are minor and we believe that they will affect only a small number of records. The purpose of the new edit is to allow us to apply new logic to item A2200 (previous ARD for significant correction). The old edit 3573 constrained this date so that it must always be greater than or equal to A1600 (entry date) and A2300 (assessment reference date). This relationship is correct for an when the new record is an admission, but can be incorrect when it is a reentry where the ARD that is referenced in A2200 applies to a previous stay that preceded the current entry date. It is for this reason that we created the new edit which has separate conditions for significant corrections that are coded in an admission vs. a reentry record (see the Group C rules). So to be clear, the only time the new edit will differ from the old edit will be when a new record is a significant correction to a prior comprehensive (A0310=[04,05]) ***and*** the record is a reentry (A1700=[2]) ***and*** the significant correction applies to a comprehensive or quarterly assessment from a prior stay. This is quite a rare combination of events and was only brought to our attention several months ago after three full years of MDS 3.0 data submissions.
20140107-001	E-Specs	I have a question regarding the new edit -3839. I understand	Version 1.12 of the MDS data specs will allow the user to

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		the reasoning behind allowing the changes to the target date and/or reasons for assessment on modifications as long as the ISC is not changed; as long as the ISC isn't changed, the modification is still using the same fields, so the modification can still proceed. There is an exception to this logic, however. If the date is changed so that a different submission specification version should be used, the ISC may not change, but the modification could then require a different set of fields. I'm guessing that is not what was intended to occur with this edit.	change the assessment reference date (ARD, item A2300) on a modification record. It is possible that the ARD could be changed to a date for which a different version of the data specifications was in effect. If this were to occur, the version of the data specs that was in effect on the new date would apply to the modified record. In some cases, this could mean that an item was active for the modified record that was not active in the original record. If the facility had not assessed that new item, they would need to submit a dash for that item to indicate that it was not assessed.
20140107-002	E-Specs	As per the MDS 3.0 data specs overview (v1.12.0) 09-18-2012.pdf document, it specifically states: "Note that the deletion of edit -3811, the addition of edit -3839, and the change to item A0800 are retroactive once V1.12 of the data specs is implemented. This means that edit -3811 will no longer apply, -edit -3839 will apply, and a dash will not be allowed for item A0800 for every record that is submitted on or after the implementation date (05/19/2013) regardless of the record's target date" The way our team is interpreting this is that all MDS assessments submitted on or after 5/19/13 will have the new edit changes and the A0800 changes. These changes will also be retroactive regardless of the MDS's ARD date. So if an MDS with an ARD of 9/30/12 is submitted on or after 5/19/13, it should have the latest edits and changes to A0800 (A highly unlikely scenario to submit such an old assessment but we want to make sure our understanding is correct) Can you confirm this is correct? Also, the document does not explicitly say that WHEN the new SPEC_VRSN_CD should be updated. In past revisions, the SPEC_VRSN_CD has been based on the assessment's target date. However, this revision's edits are based on submission date. So we want to get validation of when the SPEC_VRSN_CD should be updated from 1.11 to 1.12. Should the value sent in SPEC_VRSN_CD be based on the assessment's target date or submission date?	Here is a summary of the implementation dates: 1. The changes to edits -3811 and -3839 are effective 5/19/2013 and will apply to all records regardless of their target date. 2. The change to item A0800 is effective 5/19/2013 and will apply to all records regardless of their target date. 3. The new value for SPEC_VRSN_CD ("1.12") will become valid for assessments with target dates on or after 5/19/2013.
20121210-007	E-Specs	I have a question and was wondering if you could provide me with some insight on ICD-9 codes. A facility has brought up the fact that some of the ICD-9 codes that we allow in our	The ASAP system checks the record to determine whether the ICD-9 code submitted meets the format requirement. Please refer to the technical specifications for the required

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		application for MDS data point I8000 are not actually allowed by CMS. They referred to the following codes and their concern was that the codes with no decimal points (more generic codes) are not acceptable for I8000: • 600 - Hyperplasia Of Prostate • 707.0 - Pressure Ulcer • 733.0 – Osteoporosis • 585 - Chronic Kidney Disease (Ckd) • 724.0 - Spinal Stenosis Other Than Cervical • 786 - Symptoms Involving Respiratory System And Other Chest Symptoms They claim that they have received validation errors when submitting the MDS to CMS. • I researched in the RAI manual for Section I and submission specs and there is no explicit mention of what ICD9 codes can be used other than the fact that they have to be valid codes. I checked in ICD9cm site (http://icd9cm.chrisendres.com/index.php?action=child&recordid=5909) and confirmed that the codes listed above are valid ICD9 codes • When I imported a test file into jRAVEN, I didn't receive any validation errors stating that these codes were not allowed • I also tried using the VUT tool from QTSO (https://www.qtso.com/vendormds.html) and did not receive a FATAL error from this tool either; however, I received the following warning message for each ICD code. <results> <message_number>146</message_number> <error_id>-3591</error_id> **<severity>WARNING</severity>** **<text>The ICD-9 code could not be found in the official ICD-9 diagnosis codes for 2011.</text>** **<item>I8000A</item>** **<item_value>^^600.^^</item_value>** </results>	formatting at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html When a record is submitted and it does not meet the data specifications format, the record will be rejected. The VUT also checks the format and will issue a fatal error just as the ASAP system does. In addition, the VUT compares the ICD-9 to the official list posted on the CMS web site at: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html If the record contains an ICD-9 that is not listed a warning is issued. All the codes you listed as not on the official list. For example, 600 is not an official ICD-9 but 600.00 is. At this time, the ASAP doesn't compare the ICD-9 to the official list posted on the CMs site. Regardless of the checks CMS has in place for ICD-9 codes, it is the provider's responsibility to ensure they are using proper ICD-9 codes whether it be for the MDs or a claim or other document.

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		<results> I can't find documentation anywhere that specifically speak to this issue so I was wondering if perhaps you can provide some insight. Are these types of codes not allowed?	
20121210-008	E-Specs	When ICD-10 is implemented, we have questions regarding ICD-10 use in MDS. I am aware that I8000 is already designed to allow for ICD-10 values. Will an additional "indicator" item, calculated field, or control field be added to indicate whether I8000 is coded as ICD-9 or ICD-10? In other words, will something be added to the state extract file that will indicate whether I8000 is coded with ICD-9 or ICD-10? How does CMS plan to identify which ICD code was submitted? ICD-9 vs. ICD-10 in I8000. Has ICD version detection been developed based on the first character, the number of total characters, or some other means of distinguishing ICD-9 vs. ICD-10? If not, do you plan to develop one at some point in the future that you will be able to share so others might use ICD version detection in their own coding?	The formatting of ICD-9 and ICD-10 do differ. ICD-10 requirement will be based on target date of the assessment. Prior to the implementation of ICD-10 (today's world), the specifications require the ICD-9 format and thus the ASAP edit checks any codes entered in I8000 meet the ICD-9 format described in the Data Specifications. When ICD-10 is in place, the Data Specifications will be updated for the ICD-10 release to describe the ICD-10 format expected. The ASAP edit will check the code to ensure it meets ICD-10 format. From a CMS perspective for MDS 3.0, the ICD-10 implementation will be based on target date of the assessment (A2300). As the expected ICD code (ICD-9 or ICD-10) is based on target date not submission date, after the ICD-10 implementation date, a provider probably will still be submitting records with a target date prior to the ICD-10 implementation date. Records with a target date prior to the ICD-10 implementation date (currently scheduled to be October 1, 2014), would submit ICD-9 codes regardless of when they were submitted.
20121210-010	E-Specs	On a discharge assessment, section O: If there are no minutes in the look back, I can enter a zero for the days. For the dates (PT, OT, ST) is blank a valid answer? Or must I enter a dash?	Edits -3557, -3558 and -3559 address this issue – consistency fatal skip pattern. Please refer to the error message chapter of the Provider Users Manual, as well as the data specifications. If an item is active, it may not be left blank. An active item must contain a valid response value. If an active item is left blank, the record will be rejected. When we refer to blank, we are saying that the item does not contain a valid response value, which in some instances, the caret (^), may be a valid value.
20111110-007	E-Specs	In previous releases of item set PDF documents, there were field misnaming errors in terms of data tags applied to PDF fields that required hand adjustment to allow automatic	CMS is required to meet 508 requirements, which allows the item sets to be read and navigated by assistive technology. Our software meets the requirements for

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		printing of the PDFs. Each of the data fields has an implicit defined data tag that is part of the PDF structure and therefore, you can write programs that fill them in automatically but 3% of the fields' data tags are incorrect. The programs we write allow for hard copy printing. Will there be any attempt to put in a QA effort with the next release to correct those mistakes?	successful submission to the QIES ASAP system. Providers are not required to use the CMS software; however, they must ensure that the product they use meets CMS' requirements for submission. Vendors may choose to provide features above the CMS requirements.
20110803-002	E-Specs	I have a question about editing O0450A. **Edit -3812 b) states:** If A0310C = [0,1,4] or A0310F=[01,10,11,12], then all active items from O0450A through O0450B must equal [^] But then: **Edit -3815 states:** If X0900E=[1], then O0450A must equal [1] So if I make a modification of an Admission/14-day/Change of therapy assessment (01/02/4 which is a valid assessment combination), and then check X0900E as yes, I will have conflicting edits since A0310C = 4, O0450A through O0450B must be blank but if X0900E is checked, then O0450A must equal 1.	Item X0900E should be checked only under the following scenario: (a) an end-of-therapy OMRA (A0310C=[2,3]) has been submitted and accepted by the ASAP system (b) there has been a subsequent resumption of therapy (c) the original EOT assessment is being modified by entering appropriate information in O0450A and O0450B. Under this scenario, X0900E should be checked (equal to "1") and items O0450A and O0450B should be completed. The question concerns a change of therapy, not an end-of-therapy/resumption-of-therapy combination. Item X0900E therefore does not apply to the scenario that is described. The edit that prevents X0900E from being checked is therefore appropriate.
20110803-003	E-Specs	This query is related to two Edit IDs: -3812 and -3815. Per [Edit ID:-3812]: b) If A0310C = [0,1,4] or A0310F = [01,10,11,12], then all active items from O0450A through O0450B must equal [^]. This means that O0450A will be skipped in case either A0310C or A0310F have above mentioned values. Per [Edit ID: -3815]: If X0900E = [1], then O0450A must equal [1]. This means that when X0900E is 1, O0450A should also be 1. Now what would happen, if X0900E is 1 and the value in	We presume the inquirer is asking what would happen "if X0900E is 1 and the value in A0310C=[0,1,4]). There is not an edit that directly controls the relationship between A0310C and X0900E. However, both of these items are related to O0450A/O0450B. If O0450A/B were skipped, then a fatal error would result because of Edit -3815. If O0450A/B were not skipped, then a fatal error would result because of Edit -3812. The scenario described (coding X0900E=[1] and A0310C=[0,1,4]) does not make sense. Item X0900E should be checked only under the following scenario: (a) an end-of-therapy OMRA (A0310C=[2,3]) has been submitted and accepted by the ASAP system, (b) there has been a subsequent resumption of therapy, and (c) the original EOT assessment is being modified by entering

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		A0310C is [01]? Per Edit ID -3812, O0450A should be skipped but according to Edit ID -3815, O0450A must be equal to [1]. It seems the Resumption of therapy Modification reason would be intended to only be used for an EOT where A0310C = 2 or 3, but there is no edit to prevent X0900E from equaling 1 when not an EOT assessment.	appropriate information in O0450A and O0450B. Under this scenario, X0900E should be checked (equal to "1") and items O0450A and O0450B should be completed. The scenario described by the inquirer involves coding X0900E=[1] when A0310C does not indicate an end of therapy. Because this scenario does not make sense, the record would be rejected.
20110126-011	E-Specs	Questions S0172B through S0172G are listed in the specifications and data dictionary files with an item type of Code. Looking at the Item Values table entries listed in the specifications and data dictionary, however, it would appear that this field was intended to be a checklist. Which is the correct type?	The Section S items that you mention could probably be considered checklist items. However, we probably will not change their item types for two reasons. First, when States submit items for addition to Section S, we typically do not see their data collection forms and therefore deal with the items as discrete entities. With the information provided, it is sometimes difficult to determine what logical connections, if any, there may be among a State's items. Second, and perhaps more importantly, unlike the Federally required items, there are no inter-item edits applied to Section S. Thus, even if a Section S checklist contains a none-of-the above item, we do not enforce the expected logic between the none-of-the-above item and the remaining items on the checklist. Therefore, there is no functional difference on Section S between checklist items and items with type="Code".
20110126-012	E-Specs	This question pertains to the timing of state Section S changes that are scheduled for April 1, 2011. Is the April 1st date based on the submission date or the ARD (A2300) date of the assessment? For example, an assessment is submitted on April 2nd, but has an ARD of March 25th. Should that assessment follow the “old” (pre-April 1st, 2011) Section S specifications? Or should it follow the “new” (post-April 1st, 2011) Section S specifications? Will software vendors need to support both versions of section S for a state that has made changes? For example, if on April 5th the facility needs to correct an MDS from March 25th, must the vendor bring up the old section S, or is the new one acceptable? Do users get warnings if a Section S question is missing or not marked or would they get a rejection/fatal error message?	The new version of the data specs (V1.01) takes effect on 4/1/2011. This means that all submitted records with target dates on or after 4/1/2011 must conform to V1.01. Submitted records with target dates on or before 3/31/2011 must conform to V1.00. Please refer to the new document (“Data specs version summary”) that has been posted on the MDS 3.0 technical information web page for details about version control. Only warnings are issued for section S items when item is missing, or the response is missing or invalid.

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20101220-007	E - Specs	For the xml format, what coding should we use?	ASCII is the character set the ASAP system will accept. This is found in the MDS 3.0 Data Specifications Overview.
20101220-009	E - Specs	If the tags for an item are sent in, but no value is included or the value is all spaces, what error will occur?	If there is no value or the value is all spaces (not caret, but space), then the record will be rejected with a -1003 Required Field Missing or Invalid or a -1030 Missing Item fatal error depending on which item is missing.
20101220-011	E - Specs	What characters can be used in the name item?	The ASAP system supports ASCII encoding only. The data spec has all validation rules defined using printable ASCII characters, any other character in any item will be rejected with validation error. File submitted with non-ASCII special characters will be rejected with -1004 parsing error. The edit on name characters is: -3690 Formatting of Alphanumeric Text Items That Can Contain Dashes, Spaces, and Special Characters: If this item is not equal to one of the special values (if any) that are listed in the Item Values table of the Detailed Data Specifications Report, then it must contain a text string. This text string may contain only the following characters: a) The numeric characters: [0] through [9]. b) The letters [A] through [Z] and [a] through [z]. c) The character [-]. d) The following special characters: [@] (at sign) ['] (single quote) [/] (forward slash) [+] (plus sign) [,] (comma) [.] (period) [_] (underscore) e) Embedded spaces (spaces surrounded by any of the characters listed above). For example, [LEGAL TEXT] would be allowed.
20101101-015	E - Specs	On the NQ and NP forms, O0400D2, days of respiratory therapy, and O0400E2, days of psychological therapy are both active. The CMS specifications include this skip pattern – a) If O0400D1=[0001-9999], then if O0400D2 is active it must	The answer to this question can be found on page 10 of the data specifications overview document (MDS 3.0 data specs overview (v1.00.3) 06-01-2010.pdf). Towards the bottom of the page, the document says the following: "The relational edits that are included in the data

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		not equal [^]. b) If O0400D1=[0000], then if O0400D2 is active it must equal [^]. c) If O0400D1=[-], then if O0400D2 is active it must equal [-]. a) If O0400E1=[0001-9999], then if O0400E2 is active it must not equal [^]. b) If O0400E1=[0000], then if O0400E2 is active it must equal [^]. c) If O0400E1=[-], then if O0400E2 is active it must equal [-]. O0400D1 and O0400E1 are inactive on all forms except the NC. With O0400D1 and O0400E1 inactive on the NQ you will never have minutes which means item B in the skip pattern is active and O0400D2 and/or O0400E2 must equal ^. Why have the fields on the NQ if they are always a caret based on the CMS skip pattern? CMS specifications do not breakdown by MDS form type except for Active\Inactive. The instructions on the MDS for D2 and E2 plainly state "record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days." Maybe the minutes for respiratory and psychological are not needed but that does not help the skip pattern in CMS specifications. There is a related fatal error as well– O0400D1 must be greater than or equal to O0400D2*15. O0400E1 must be greater than or equal to O0400E2*15.	specifications apply only to items that are active for a particular item subset. Items that are not active on a particular item subset should not be submitted and are not edited even if they are submitted. For example, consider an edit that says "If Item A=[1], then all active Items B, C, and D must equal [2]". If Item A was equal to [1], then any of the items B, C, and D that were active must equal [2]. However, if any of these three items (e.g., Item B) was inactive, it would not be submitted, would not have a value, and would not be edited. The edit would therefore not apply to the inactive item but would continue to apply to the remaining active items, if any. Similarly, if Item A was not active, the entire edit would not apply." Let's use respiratory therapy (O0400D) as an example. On an NC, both O0400D1 (minutes) and O0400D2 (days) are active. Therefore, Edit -3560 (which deals with the skip pattern) and Edit -3699 (which describes the mathematical relationship between days and minutes) both apply. However, on an NQ, only the "days" item is active. Therefore, both of these edits are suspended. The only remaining rules for the "days" item are the formatting rules and the allowable range of values. Thus, the days item would not always be skipped on an NP or NQ, as was stated in the question.
20101101-014	E - Specs	For a PPS assessment (NP) where Z1 is not there (it is not on the print), how is O0100 A1 - Z1 coded if the assessment is done within the first 13 days?	On an NP being completed within the 14 day lookback period, O100A1 - O100J1 would be assessed individually and only checked (code value 1) if the treatment occurred prior to admission/reentry to the facility and within the 14 day lookback period. If the item is assessed and it is determined that the treatment did not occur prior to admission and within the 14 day lookback period, then the item then is not checked (code value 0). The item O0100Z1 is not active on an NP so it is not answered. Not answering O0100Z1 does not affect the answers to O100A1 - O100J1. The values in the items O0100A1 - O0100J1 are coded per the 1.00.3 data specifications.
20101101-010	E - Specs	How are dates supposed to be submitted when they are unknown or ongoing (-)?	Dates must be submitted based on the submission specifications for the particular date item and instructions from the MDS 3.0 RAI Manual. Depending upon the

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			particular date fields, the data specs can allow either a single dash ("-") or a string of eight dashes ("--------"). Whether either or both of these values are allowed depend upon the specs for the individual item you're talking about. If you look at the specs for A2400C, you'll see that eight dashes are allowed, but a single dash is not. If you look at O0400B5, you'll see that a single dash is allowed, but eight dashes are not. Finally, if you look at O0400B6, you'll see that either a single dash or eight dashes are allowed. The general rule for these date items is that a single dash is used the same way as on most other items -- to indicate that the item was not assessed or that information was not available. The use of eight dashes is generally reserved for special meanings. For example, for O0400B6, eight dashes indicate that therapy is ongoing.
20101101-006	E - Specs	Is there a standard as to where Section S items should be submitted on an xml file? Should the items be submitted in alphabetical order or should Section S be after Section Z?	There is no order requirement for items on the submitted XML records. The items in the XML file can be submitted in any order. As long as all the items active on the ISC are submitted, the order doesn't matter.
20100926-012	E - Specs	Section N on the NQ set doesn't have a Z - None of the Above - Is this an oversight? It has the None of the Above on the NC set.	There are several other items on different MDS 3.0 item sets where a None of Above item is not active or is missing from the item listing. This was intentional as the definition of the None of the Above depends on what items are in the list. In the cases where the None of the Above item is active on the NC and not active on the NQ, the NQ does not contain all of the items in the list. The item list referred to in Section N is N0400A - G and N0400Z (None of the Above). In the item set N0400Z is defined as not having N0400A - N0400G. On the quarterly, only N0400A - N0400D are active and N0400E - N0400G are not active. For the quarterly, a None of the Above item would be defined as referring to N0400A - N0400D. If N0400Z was used, then this is a different definition of the same item. If states choose to add all three items N0400E - N0400G to their NQ or NP assessments as state optional fields, then they can also add N0400Z as all the items in the list will be active so the None of the Above will have the correct meaning. The ASAP system will only edit a checklist if all possible items are active within that checklist.
20100926-011	E -	The tracking forms, Entry and Death in Facility, do not have an A2300 or a Z0500B date required on the form, will the	CMS will calculate a target date for all records except for inactivation requests based on the MDS 3.0 Data

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	Specs	CMS system calculate either a target date or an effective date for either of these forms?	Specifications. The target date is defined in the MDS 3.0 Data Specifications under edits -3658 and -3762 as well as under information -9017 under target date in the Calc section. The calculated effective_date is not calculated and will always be blank filled. See information -9018 under effective_date in the Calc section of the MDS 3.0 Data Specifications
20100720-047	E - Specs	How will the assessment internal ids be assigned? Will you re-use any numbers previously used in MDS 2.0, or will the numbering scheme be totally different? We need to find this out in order to design the database.	A new sequence will be used for the MDS 3.0 assessment IDs. This sequence will be for all MDS 3.0 records submitted from all states, both NH and SB. Each MDS 3.0 Assessment ID will be unique. An MDS 3.0 assessment id may have the same value (number) as an MDS 2.0 assessment_internal_id in one or more states.
20100420-Ad Hoc11	E - Specs	Is A2400, Medicare start of stay, a required field that has to be entered? Will that date (whatever the date is), be entered for each assessment until such time as the stay ends?	The answer to both questions is yes. It is a required on all types of assessments, except on an inactivation. Yes, continue to enter it during the course of the stay. You indicate the start and end date of most recent Medicare coverage stay.
20100420-37	E - Specs	Where can I find a listing of the items that are included on the different MDS assessment types - like Discharge Assessment, Quarterly Assessment, PPS only assessment, etc?	Go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html website, download the current version of the MDS 3.0 Data Submission Specifications, Open the data specs CSV files zip file. The information is in the itm-sbst .csv file. It has a title row of all the item subsets (abbreviated) and a column with all of the item names. There is an 'x' at the intersection of item row and ISC column which indicates that item is in that ISC.
20100420-33	E - Specs	Is there a specific program that we need to use to create the zip submission file?	The MDS 3.0 submission system uses a Java stored procedure to unzip the submission files. The utility is implemented using the Java 1.5.0_11-b03 Java virtual machine included with the Oracle database. The Java utility class is called JAVA.UTIL.ZIP. Although we have not been able to find a specific listing of support for other zipping tools, we found recommendations to use normal PKZIP and WINZIP applications. There are many ZIP programs on the market and many of them have added their own proprietary 'SUPER COMPRESSION' which will NOT be supported by

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			the submission system. Developers can also use the JAVA.UTIL.ZIP class to ZIP their own files. The class files can be found in the Sun JVM. We believe the implementation is the same across the different versions of Java. Developers should consult their Sun Java documentation for specifics. Yesterday, we completed a test using the Microsoft Folder Compression. The submission was successfully unzipped with 3 files for processing. According to Microsoft, their folder compression comes in 2 flavors based on the FAT32 or NTFS file system. We tested with NTFS. Microsoft says the folder compression creates a compliant ZIP file. We were able to successfully unzip the file created with the MS Folder Compression using WinZip. Microsoft added one caveat with respect to its use. The Folder Compression is meant to be used from the OS. Microsoft does not provide any means to call this compression from any other program. Do not zip the individual records before including them in the final zip file.
20100225-085	E - Specs	What is the FAC_ID (Assigned facility/provider submission ID) and how is it obtained? Is this the same value as the MDS 2.0 FAC_ID?	The FAC_ID is the same FAC_ID as for MDS 2.0. It is the state assigned facility identifier.
20100225-080	E - Specs	Since the Inactivation has active items for sections A and X only, can we expect an Item Subset document that includes only those 2 sections?	No. There will not be an Item subset for an inactivation. Inactivation records only have control items and Section X items active. There are no active Section A items for an inactivation.
20100225-062	E - Specs	Edit id – 3573, in the Group A Rules, there is an entry "**A2300 (assessment reference date) = A2000 (discharge date)"** that I don't fully understand. What logic does the "=" stand for in this case? Does the "=" mean that the ARD should be the same as the Discharge date?	If the discharge record is combined with another assessment that requires an ARD to be entered, then the discharge date (A2000) must be the same date as the ARD (A2300). Two assessments may not be combined into one record if they have two different target dates. Hence if submitted in the same record and both dates are not skipped [^], they must be equal.
20100225-054	E - Specs	Will section X of MDS 3.0 be used in the same way as the MDS 2.0 prior section, so that MDS 3.0 section A contains the new data for the assessment and section X is only used	Yes. Section X is used to identify the Type of Record in X0100 (add, modify, inactivate) and to identify the record to be modified/inactivated (X0100 = [2,3]) and the reasons for

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		to identify the assessment for which to modify or inactivate?	this modification/inactivation. The information in Section A on a modification record (X0100 = 2) is the new information for the modification.
20100225-050	E - Specs	There is a short list of 9000 series "informational" edits in the specs. Some of these imply that a possible edit could be in place. Are these part of the standard "validation" edits or are these not included in the validation process.	They are informational only and are not included in the MDS 3.0 submission system edits or messages.
20100225-029	E - Specs	The specs for the item a0500b (resident middle initial) has a maximum length of 1. Edit -3691 says that if a0500b is not a special value (^) that it must only the following characters (0-9, a-z, A-Z, @, ', / , . , , , + , _ .). These characters are listed below. What middle initial would be a number or one of the special characters?	CMS has decided to leave this edit unchanged. Vendors are free to enforce a more restrictive edit on this item if they wish.
20100225-027	E - Specs	Why does the isc_val database table include entries for the ISC of '—'which is invalid? The pseudo code assumes that all other combinations are to be assigned '—'so why have these entries? The isc_val table contains values for a0200 which are not allowed, specifically ^. The isc_val table contains values for a0310a which are not allowed, specifically ^. The isc_val table contains values for a0310b which are not allowed, specifically ^. The isc_val table contains values for a0310c which are not allowed, specifically ^. The isc_val table contains values for a0310f which are not allowed, specifically ^.	The isc_val table includes all possible combinations of the fields A0200, A0310A, A0310B, A0310C, A0310D, and A0310F. Edit -3607 defines the allowed combinations which will produce a valid ISC. The invalid ISC's are noted in the table by a '—'. This table is for the convenience of developers if they wish to use it. Per the MDS 3.0 Data Specifications Overview document posted on the CMS MDS 3.0 Technical page: "There are 3,360 combinations of the possible values of these six RFA items. Most of these (2,542) are combinations of values that are not allowed (i.e., that will lead to record rejection). The remaining combinations can be mapped onto the ISC codes described above. Unfortunately, the logic for determining the ISC is not straightforward and cannot be reduced to a set of simple rules. To assist programmers, we have provided two options for determining the ISC code from the RFA items. The first option is to use a lookup table that is supplied with the data specifications. In the Access database, this table is called isc_val. The contents of this table are supplied with the data specs in a comma separated value file called isc_val.csv. This table contains one record for each of the 3,360 combinations of the ISC items. It also includes one additional record that corresponds to an inactivation ISC ("XX"). Each record contains a unique combination of the RFA items in the fields named "_val" (i.e., in A0200_val, A0310A_val, etc.). The ISC that is associated with the RFA combination is in the field called isc_id. If this field contains dashes ("--"), the combination of RFA values is not allowed. "Instead of

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			using the lookup table, the programmer can implement the logic that is shown in Appendix B. This appendix contains the source code for a Visual Basic function that accepts the values of the six RFA items as string input, and returns the ISC value as a string. If the RFA combination is invalid, the function will return dashes ("--")."
20100225-015	E - Specs	Edit -3789 states: RULES FOR NEW RECORDS (WHERE X0100=[1]): a) If A0310A is equal to [01,03,04,05] (this is a comprehensive assessment), then submission date -V0200C2 (care plan completion date) should be less than or equal to 14 days. b) If A0310A is equal to [02,06] (this is a quarterly assessment), then submission date -Z0500B (assessment completion date) should be less than or equal to 14 days. c) If A0310A is equal to [99] and A0310B is equal to [01,02,03,04,05,06,07] (this is a PPS assessment), then submission date -Z0500B (assessment completion date) should be less than or equal to 14 days. d) If A0310F is equal to [10, 11] (this is a discharge assessment), then submission date -Z0500B (assessment completion date) should be less than or equal to 14 days. e) If A0310F is equal to [01] (this is an entry record), then submission date -A1600 (entry date) should be less than or equal to 14 days. f) If A0310F is equal to [12] (this is a death in facility, record), then submission date - A2000 (discharge date) should be less than or equal to 14 days. Since I can have an NC record where A0310A = 1 and A0310F = 10 (for example), which rule applies, (a) or (d)?	In your example (where a discharge is combined with a comprehensive assessment), both rules would apply. Each of these rules is applied independently.
20100114-062	E - Specs	Will there be documentation on what has changed in the new version of the specs?	Yes. When you download the new version of the specifications, you will see there are two new reports: a Item Change Report and a Edit Change Report. These reports will give you a description of the changes.
20100114-043	E - Specs	What will the new requirements be for calculating Length of Stay (LOS) within the MDS 3.0? When can we expect this information to be finalized?	The only place that an MDS 3.0 length of stay (LOS) measure is used in the QIES ASAP System is in the RUG-IV grouper. In order for the Special Medicare Short Stay RUG-IV rehabilitation classification to be used on an assessment, the end of the Medicare stay must be no later than the 8th day of the stay. This means that the Medicare End of Stay Date (A2400C) minus the most recent entry date (A1600) must be less than or equal to 7.

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20100114-023	E - Specs	Is an ARD (A2300) required on all assessments, including the discharge and reentry?	Item A2300 (assessment reference date) is an active item and is required on all MDS 3.0 records *except* the following: entry records (A0310F=01), death in facility records (A0310F=12), and inactivation records (A0050=3).
20100114-013	E - Specs	Z0300A and Z0300B Insurance Rugs are on the forms but not in the data specs (not submitted assumed). Z0400 (items a-l) are on the form but not the specs (not submitted assumed). Z0500A is on the form but not in the specs (not submitted assumed). In the data specs after the item Z0500B there is a list of items associated with the state or CMS side of the submission. We assume that a vendor has no need for this info unless in conjunction with state or federal submission outside of the normal process.	Z0300A and Z0300B (insurance RUGs and version) are not included in federal submissions to the ASAP system. These items are included on the printed item sets for the convenience of providers that need to submit MDSs to insurance companies. In the data submission specifications, Z0500B is the last item that is included in federal submissions to the ASAP system. Filler and calculated items follow this item. The filler and calculated items are not included in federal submissions. When building a fixed-format string, these items should normally be blank-filled (except for the data end, carriage return, and line feed items). The calculated items will be populated in files received from CMS.
20121210-012	F-State Options	I have questions about what the states can setup so that the Z0200 and Z0250 RUG scores are validated by the *ASAP MDS Validation System*. It would be helpful to know this information so that we can mirror the available RUG setups in our products.	The discussion below describes what the ASAP system will do. If the state wants to do any other type of Medicaid calculation, the state must do that in their Medicaid system. It will not be done by the ASAP system. If the state wants the ASAP system to recalculate the Medicaid RUG values on an MDS 3.0 NP, NQ, or NC assessment, the state can set up the parameters in the MDS 3.0 DMS. This set up of parameters in the MDS 3.0 DMS will cause the ASAP system to recalculate the Medicaid RUG submitted based on the parameters entered by the state into the MDS 3.0 DMS. The parameters that the state can set in the ASAP system are listed in the consolidated Q & A's on the MDS Vendor page in question 20101101-025 The ASAP system only allows the state to choose the following parameters when having the ASAP system recalculate Medicaid RUGs 1 - Choose RUG IV version 1.00 model 66, 57 or 48 or RUG III version 5.20 model 53, 44, or 34.

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			2 - Choose a CMS defined CMI code set(s) or create a specific state defined CMI code set(s) for urban and for rural for the calculation. 3 - Choose the beginning and ending effective dates for which the Medicaid RUGS will be calculated. The target date of the assessment will be compared to the beginning and ending effective dates for the RUG calculation. If the target date is equal to or greater than the beginning date and equal to or less than the ending date, the RUG will be calculated. At this time, the state cannot choose the rehab parameter in the MDS 3.0 DMS. The ASAP system always uses "OTHER" for the rehab parameter in recalculating the Medicaid RUGs. Beginning on October 1, 2014, states will have the option to select any rehabilitation parameter for their Medicaid RUG calculations that is supported by the standard CMS RUG code.
20121210-013	F - State Options	We are software vendors in the state of Illinois. We have a question regarding items collected for NQ ISC for the state of Illinois. As per the Additional items required document published by the CMS, it is required to include all V section elements in the NQ assessment. When one of our clients checked with the state coordinator, then have indicated that there is no need to submit V sections in NQ. Following are my questions: 1. Is there any other document besides the one published by the CMS? 2. Is it mandatory to submit the V sections in the NQ for the state of Illinois? 3. If the MDS is submitted without V section will it be rejected? Moreover, in the jRAVEN software V section is not included for the state of Illinois. Please clarify whether to include the V section or not in the	The Additional Items Required by States that is a link published on the Vendor Section of the QTSO website: https://www.qtso.com/vendormds.html is correct. Illinois collects all CMS defined items EXCEPT for G0900A, G0900B, and (also except for) all Section V items. All Section V items are within this exception list so are not collected. In the future, for state specific issues/questions, please contact the state directly.

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		NQ assessment for the state of Illinois. https://www.qtso.com/download/mds/Additional_Items_Required_by_States_for_Nursing_Home_MDS_05092012.pdf.	
20110126-016	F-State Options	In New York, they are adding two Section S fields and eliminating others effective April 1; can all fields be submitted for a short period of time after April 1?	Section S fields that are not active but submitted anyway, (as long as they are formatted correctly), are ignored. They are not stored, edited, nor receive warnings.
20101220-013	F-State Options	It would be extremely helpful if CMS would publish which RUG each state selected for Z0200 and Z0250. States are not reporting that information accurately to us. In fact, one state told us version 09 and there is no 09.	There is a RUG version 09. It is RUG III, 53 group, version 09. The grouper version code that the grouper returns (found in the RUG III grouper specs posted on the CMS website) will be 07, 08, or 09, depending upon the number of groups.
20100820-030	F - State options	Since the file is being sent to CMS first and then CMS is providing the data to the states under MDS 3.0, our question is whether vendors have to filter for state excluded values such as STDs and HIV or will CMS filter those values before providing data to the states from the national system?	It is the state regulation/law/statute that requires NO submission of identified HIV and/or STD diagnosis; therefore, providers should take the appropriate editing to prevent this from happening. The QIES system will edit out a specific ICD-9 code that the state determines inappropriate and designates as such in the CMS QIES system. This does not supersede the provider from submitting the banned codes i.e. the state may inadvertently miss adding such banned codes in the CMS QIES system. The onus is on the provider to ensure they are compliant with state specific requirements.
20100820-009	F - State options	A State uses a Comprehensive without section V for their Quarterly MDS Assessment. How will the ASAP computer system edits know what should be on this state's Quarterly? What if someone uses jRAVEN? Will CMS create a form for the specific state Quarterly Assessment? If so, how can I get a copy?	States can request CMS to add items to the OBRA quarterly (NQ) and/or PPS (NP) assessment for their state. The items available for addition to these ISCs are identified by an 's' (lower case letter s) under the ISC column in the MDS 3.0 Data Specification's file itm_sbst.csv or by having the NQ and NP item subset codes listed in the State optional: NQ,NP line for the item in the MDS 3.0 Data Specifications Detailed data specs report. After approval by CMS, CMS will update the ASAP system to add the requested items to the requested NQ or NP assessments for that state as active items. As active items, they will be edited and stored by the ASAP system. If any of these active items are missing or fail a fatal edit, the record will be rejected. For example, a state has requested and been approved to have all the available items that are not in Section V added

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			to their OBRA quarterly (NQ) records effective October 1, 2010. All NQ records submitted in this state with a target date on or after October 1, 2010 will have these requested items active. This is a change to the items on the state's OBRA quarterly (NQ) record. It is not a different type of comprehensive (NC). If providers send in an NC that is missing the Section V items, it will be rejected. Section V items are active on NC records. JRAVEN has functionality to accommodate the specific state's quarterly additional items. CMS does not create state specific printable item subsets.
20100720-040	F - State options	I have a couple of questions on how corrections will be handled in the daily file that will be “pushed down” to CMS QIES servers at each state: Each record has a MDS _ASMT_ID and an ORGNL_ASMT_ID. 1) When A0050 = 1, Add new record, are the values for both the MDS_ASMT_ID and ORGNL_ASMT_ID the same? 2)When A0050 = 2, Modify existing record, is the ORGNL_ASMT_ID always equal to the value assigned when the assessment was first added, regardless of how many modifications are submitted? 3) If a nursing home adds an assessment record and on the same day submits two modifications of this record, what order will these records be listed in the daily file? What will be the sort order of records in the daily file?	1) When A0050 = 1 the values for both the MDS_ASMT_ID and ORGNL_ASMT_ID will be the same value. 2) When A0050 = 2, Modify existing record, the ORGNL_ASMT_ID will always equal the original value assigned when the assessment was first added, regardless of how many modifications were submitted. 3) There is no sort order on the state extract file. Note: If the state wants to process them in a certain order then they can sort them prior to processing. With MDS 3.0, submitters were not required to put a zero in X0800 Correction Number for original records. If it is an original record X0800 is part of a skip pattern so is a caret. The values of X0800 are caret (^) for an original record and 1 through 99 for a modification or inactivation record.
20100720-014	F - State options	Z0250 - Alternate State Medicaid Billing (RUG and RUG version) Do the states have a way to set up this field so that the "^ (Blank, not available or unknown)" is not a valid option?	Z0250 - If a state sets up parameters for the ASAP system to perform Medicaid RUGS calculation 2 (Z0250A), then the ASAP system will recalculate the Z0250A value and issue warning edit -3616 if they do not match. This includes issuing the edit if a blank is submitted and the state sets up Z0250A to be calculated by the ASAP system.
20100720-011	F - State options	Z0250 is active on the NC, NQ, and NP subsets but is inactive on the remaining subsets. Do the states have a way to make the remaining subsets (except XX, I guess) active?	No, states can only add items to the NQ and NP ISCs. They cannot add non-section S items to any other ISC.
20100926-017	F –	Is it possible to get a copy of your state-optional info as we	The document, Additional Items Required by States for

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	State options	did the Section S info?	Nursing Home MDS 3.0 Assessments is posted on the vendor link of the QIES Technical Support Office website: https://www.qtso.com/vendormds.html. This document lists the States that have been approved for additional CMS defined items on their Quarterly (NQ) or PPS (NP) assessments.
20100926-016	F – State options	Will there be an alternate Item Subset posted for a full Quarterly (ISC = NQ) without Section V? So far 2 states have elected to utilize all state optional items, except Section V. If not, which subset are we to use for the printed MDS 3.0 NQ when the state requires a full quarterly?	CMS does not create state specific printable item subsets.
20100820-016	G - Section S	How will the ASAP system edit Section S items with an Item Type of TEXT?	The ASAP system edit for Section S items with an Item Type of TEXT (S0140, S0141, S0150, S6100F1, S6100F2, S6100F3, S8050B, S8050C, S9020, S9080C) accepts all printable characters as valid values. The submitted values are trimmed of all leading and trailing blanks (ASCII hex '20'). If all characters in the submitted value are blanks (ASCII hex '20'), they will be trimmed off and the value of the item would be considered missing. A missing value will receive the -3808 warning message. To designate that the item has been addressed and is blank, a caret (^) should be sent as the value for the Section S TEXT item values. A caret is accepted by the ASAP system as a valid character and no warning message is issued. Note: The ASAP system will edit items per the MDS 3.0 Data Specifications. The States can implement additional requirements for Medicaid purposes; however, the ASAP system will edit based on MDS 3.0 Data Specifications.
20100820-015	G - Section S	If a state asks for items where the instructions or intent requires a skip what is expected in the data. For instance S6050 is asking if Isolation Precautions are needed and if you answer Yes then you answer S6051A, B, C, D checkboxes. The specs allow for a 0, 1 in the checkboxes. But if they are skipped should they be blank or contain a caret? How will the VUT handle cases where the value is out of the range of the specs in a case like this?	The response options that are listed in the data specs for the Section S items were provided to CMS by the States. A skip (caret) is not listed as a valid response for the S6051A-D items and should therefore not be submitted. If a caret was submitted for these items, it would trigger Edit - 3808, resulting in a warning. Furthermore, enforcement of a skip pattern like the one mentioned is outside the scope of ASAP because the system does not enforce relational edits for Section S. This is something that the State might choose to enforce in its Medicaid processing system. We

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			therefore recommend that the vendor contact the State responsible for the items in question to find out how they should be handled in the situation he describes.
20100420-Ad Hoc21	G - Section S	Will vendors be required to contact States to find out what the Section S format should look like?	Yes, contact state agencies. We did include item text for Section S items in the new version (1.00.2) of the data specs. CMS has been reminding state agencies they need communicate with vendors about Section S.
20100926-019	G – Section S	How will CMS transmit Section S data to the various states? We are hearing terms like the "translator". Is this an individual state program which would receive the Section S data then create a RUGs III/ reimbursement rate for Medicaid residents? How exactly does this work?	CMS will supply the accepted MDS 3.0 records to the appropriate state in a standard process. This includes all data in the record including Section S.
20121210-014	H - VUT	Can you help me understand why the VUT is telling me that -3676 (invalid value A0050) is failing when the following is true • SPEC_VRSN_CD = 1.02 • X0100 = 1 • A0050 is NOT PRESENT If the VUT is applying 1.02 rules for the submission specifications, I cannot see how error -3676 would apply since it was not added until 1.10. Does the VUT only support a single version of the submission specifications (1.10) or does it look at SPEC_VRSN_CD to determine which version to apply?	The VUT determines what items should be present in the assessment based on the target date, not the SPEC_VRSN_CD.
20100926-021	H - VUT	I also want to know if there is any variance that would justify testing in multiple states?	The VUT could be utilized for testing Section S and state optional items.
20100926-020	H - VUT	Is the VUT tool the exact same software used on the CMS server to validate assessments?	No, the VUT enforces the edits as part of jRAVEN and can be used to validate MDS 3.0 submission files in XML format, but it is not used as part of the ASAP system.
20100820-041	H - VUT	Could you provide the edits you used for your utility tool in a document? I want to compare them to our edits to be sure that they are complete and accurate.	If you haven't done so, try looking through the MDS 3.0 Technical Information page. It has information on the MDS edits as well as data specs. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-

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			Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html. The VUT uses the specs MDB for just about everything, except it also has an ICD9 lookup, the CAA rules, and it has configuration files to know what Section S and extra quarterly items are active for each state.
20100720-022	H - VUT	Do you have the actual code that performs the VScan? We would like to start with whatever code/pseudo code there is.	CMS will not be providing source code for the VUT. Historically, we did not provide source code for the MDS 2.0 validation DLLs of the past, either.
20100820-049	I - jRAVEN	Will swing bed providers still be able to use the RAVEN software? If not, does CMS have a vendor similar to RAVEN? Trying to determine transition.	Yes – a single install of jRAVEN supports both nursing homes and Swing bed facilities.
20100820-046	I - jRAVEN	What are the system requirements for jRAVEN?	jRAVEN requirements are located on the QTSO website: www.QTSO.com.
20100114-033	I - jRAVEN	Will the new version of RAVEN support other file formats?	The application will provide the user the ability to export zipped XML files and the capability to export files as standard fixed text files.
20100926-025	J - Test	We are a software vendor that would like to begin file submission testing with the MDS 3.0. Can you please advise us on how to do this?	There is not a test system available to send test assessments through to the new MDS 3.0 system. There is, however, a Validation Utility Tool (VUT) that can be used to validate MDS 3.0 submission files in XML format. The tool enforces the edits that are mapped to the MDS 3.0 items, as published in the MDS 3.0 specifications
20141021-011	K-RUGs	I have a question regarding Medicaid RUGs data in Z0200A and Z0250A. If a facility submits an incorrectly calculated RUGs group in either of these fields, will the recalculated RUGs group(s) be included in the Final Validation Report? The CMS submission specs for edit -3616 states the following: "For items Z0200A, Z0200B, Z0250A, and Z0250B, the submission system will recalculate the submitted RUGs code and RUG version code if the State is using a CMS supported RUG model. A warning will be issued if the recalculated codes do not match the submitted codes." Based on this information, it sounds like the recalculated information is on the Final Validation Report. I know that recalculated Medicare RUGs groups are on the Final	If the state has set up for the ASAP system to recalculate Z0200 and also if desired, Z0250, then the ASAP system will do the recalculation and issue -3616 if the submitted value differs from the recalculated value. Both the submitted value and the recalculated values are displayed after the Item Values: heading of the message. The MDS 3.0 Item(s): heading lists the RUG calculation(s) that did not match. The -3616 message is formatted the same with the same information for all RUG items, Z0100, Z0150, Z0200, Z0250.

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		Validation Report, but I'd like to verify one way or another whether the recalculated Medicaid RUGs groups are. Does it make a difference whether the state uses RUGs III or RUGs IV?	
20141021-012	K - RUGs	A client is having 3 MDS assessments rejected by the QIES system –and being recalculated at the default rate. According to our calculations – the resident qualifies for the short stay criteria.	The 3 assessments in question were all rejected because of fatal edit -3804. If an assessment is coded as a Medicare start of therapy assessment (A0310C = 1), then it must result in a RUG-IV rehabilitation therapy group (starting with "R") in the Medicare HIPPS code (item Z0100A). None of the assessments can qualify for the special Medicare short stay provision. They all are missing a condition that is necessary for the short stay provision that at least one of the 3 therapies must end on the therapy reference date (therapy end date must equal the assessment reference date A2300) or the end date for a therapy must be coded as "on-going" (coded as 8 dashes [-------] on the assessment reference date). For all 3 assessments, the therapy end dates (e.g., O0400B6) are coded as a single dash (-) meaning not assessed or unknown. So all 3 assessments fall the short stay provisions and must meet the regular therapy minutes, days, and restorative nursing requirements for rehabilitation classification. Using the regular criteria for rehab, the first 2 assessments fail to qualify for rehab classification because the distinct calendar days of therapy (O0420) are only 2 days but at least 3 days are required for the lowest rehab category. The third assessment fails rehab classification because, while it has 3 calendar days of therapy and could qualify for low rehab, the 2 restorative nursing procedures required for low rehab are not present. To qualify as start of therapy assessments, these 3 assessments should have therapy end dates indicating that therapy ended on the assessment reference date (e.g., O0400B6 = A2300) or therapy was ongoing on the therapy reference date (coded as --------).
20141021-013	K -	Our assessment is being rejected with fatal error -3804. The	First, the error message does not say that the "submitted"

ID	Topic	Question	Answer
	RUGs	error says that Z0100A must begin with the letter R. The submitted RUG is RVA17. We are unclear what the issue is & need assistance. The assessment values are as followed: A0310A Type of assessment: OBRA 01. Admission assessment (required by day 14) A0310B Type of assessment: 01. 5-day scheduled assessment A0310C Type of assessment: OMRA 3. Start & End of Therapy A0310E First assessment since most recent entry 1. Yes A0310F Entry/discharge reporting: 99. None of the above A1600 Entry date (date of admission/reentry in facility) 9/5/2014 A2300 Assessment reference date 9/10/2014 A2400A Has resident had Medicare-covered stay 1. Yes A2400B Start date of most recent Medicare stay 9/5/2014 A2400C End date of most recent Medicare stay 9/10/2014 O0400A1 Speech-language/audiology: individ minutes 0104 O0400A2 Speech-language/audiology: concur minutes 0000 O0400A3 Speech-language/audiology: group minutes 0000 O0400A4 Speech-language/audiology: number of days 3 O0400A5 Speech-language/audiology: start date 9/8/2014 O0400A6 Speech-language/audiology: end date 9/10/2014 O0400B1 Occupational therapy: individ minutes 0132 O0400B2 Occupational therapy: concur minutes 0000 O0400B3 Occupational therapy: group minutes 0000 O0400B3A Occupational therapy: co-minutes 0000 O0400B4 Occupational therapy: number of days 3 O0400B5 Occupational therapy: start date 9/8/2014 O0400B6 Occupational therapy: end date 9/10/2014 O0400C1 Physical therapy: individ minutes 0139 O0400C2 Physical therapy: concur minutes 0000 O0400C3 Physical therapy: group minutes 0000 O0400C4 Occupational therapy: number of days 3 O0400C5 Occupational therapy: start date 9/8/2014 O0400C6 Occupational therapy: end date 9/10/2014	Z0100A value must start with an “R”. Rather it says that the value of Z0100A (Medicare Part A HIPPS code) **“calculated by the QIES ASAP System”** must begin with the letter R if the value submitted in item A0310C (PPS Other Medicare Required Assessment) is 1 or 3. The problem with the record is that the submitted Z0100A value of RVA17 is incorrect. The correct value calculated by the QIES system did not start with an “R”. To qualify in the RV category there must be 5 distinct calendar days of therapy (O0420) and the value on this assessment is only 3. In fact 5 distinct calendar days of therapy are also required for the RU, RH, and RM categories. The only rehab category that allows the 3 distinct days of therapy on this record is RL. The RL category also requires 2 or more restorative nursing services at 6 or 7 days a week. Although the restorative nursing values were not provided, this assessment obviously does not have the 2 restorative nursing services. The correct RUG group falls below the rehabilitation categories, so the record was rejected as the correct RUG is not a rehabilitation RUG (first letter = R).

ID	Topic	Question	Answer
		Total therapy minutes = 375 O0420 Distinct Calendar Days of Therapy = 3 G0110A1 3. Extensive assistance - resident involved in activity, staff provide weight-bearing support G0110A2 2. One person physical assist G0110B1 3. Extensive assistance - resident involved inactivity, staff provide weight-bearing support G0110B2 2. Two+ persons physical assist G0110I1 2. Extensive assistance - resident involved inactivity, staff provide weight-bearing support G0110I2 2. One person physical assist G0110H1 1. Supervision - oversight, encouragement or cueing G0110H2 1. Setup help only Total ADL = 5 Z0100A = RVA17	
20141021-014	K - RUGs	Question on Z0200A. The State Rug on the MDS can be anything the state wants but if the state is using a Rug III 34 for instance and the state is recalculating the RUG III for verification does the edit only look at the first 3 characters of Z0200A or does it look beyond that. A state is adding a HIPPS modifier for a state rug. I do not know if they will want the HIPPS code which is (A0310A value) appended to the 34 RUG or not but if they do I want to know if there will be issues with MDS submission.	The state can require anything to be submitted in the Medicaid RUG fields (Z0200A and Z0250A). It could be a standard RUG group code, a standard RUG group code with a HIPPS modifier, or any other code. In all cases, the submitted value will be accepted, stored in the QIES database, and sent to the state with the MDS record. The only issue arises if the state has opted to have the QIES system verify a standard RUG code. In that case, the facility will get a warning if the submitted RUG value does not match the correct standard RUG value. So if the state opts for Medicaid RUG verification, a submitted RUG code with a HIPPS modifier will always produce a RUG warning for every record.
20140107-016	K - RUGs	In the file "o0420_mcar2_test_v2.txt", record #2, A2300="20131001". I'm having trouble since my RUG calculation program treats any assessment with A2300 >= '20131001' as having srehabtype = "MCAR3". Because of this, I'm getting l_rehab_medium=0 and the value in the record is 1. Should A2300 >= '20131001' be the trigger for srehabtype = "MCAR3" or is there some other way to determine the value?	You should not automatically set sRehabType to MCAR3 (uses distinct calendar days of therapy) if the assessment reference date (A2300) is on or after 10/1/2013. While that is appropriate for SNF Medicare Part A classification, the grouper will allow other sRehabType values for assessments on or after 10/1/2013. The grouper has been designed to allow use for purposes other than Medicare Part A classification. The grouper can also be used for Medicaid classification, other payer classification, or

ID	Topic	Question	Answer
			research. To allow such flexibility, the sRehabType parameter can be set to any value irregardless of the assessment reference date. The test file in question (o0420_mcar2_test_v2.txt) was designed to test MCAR2 classification when the assessment reference date is on or after 10/1/2013. To match the known classification results in the test file the input parameters for classification must be: sRehabType = 'MCAR2' sModel = '66' nCmiArray = set all 72 elements to 0.0 This is explained in the test data documentation on page 21.
20140107-017	K - RUGs	Regarding the RUGs version 1.00.4, I don't see any updated .sas file. Unfortunately, we do not have the ability to call DLL's from our programming language so we normally do our coding based on the .sas file. So far, I can see only RUG520.sas, dated 08/04/2005. Am I missing something or will there be an updated .sas file?	CMS does not provide a SAS version of the RUG III Conversion. The RUG III conversion logic is documented in the MDS 3.0 Conversion download package and may be used to write you own SAS code.
20140107-013	K - RUGs	Is the RUG III converter v1.00.4 backwards compatible?	Yes, the RUG-III converter v1.00.4 is backwardly compatible. The converter includes date controls to determine which items to use. For example, for assessment reference dates before 10/1/2013, the MDS non-oral nourishment item K0700A is used by the converter. On or after 10/1/2013, the new replacement item K0710A3 is used.
20140107-014	K - RUGs	Will you be putting out a new version of the RUG-IV grouper to handle the thirteen day transition period from 10/1/2013 thru 10/13/2013? Or will it be up to the software developers who use your provided RUG-IV grouper to handle?	For assessments with assessment reference date (target date) from 10/1/2013 through 10/13/2013, an FY2013 Medicare transition RUG will appear on the Final Validation Report under error message number -1067. This transition RUG is to be used to bill any days of service before 10/1/2013 for that assessment. No FY2014 Medicare transition RUG can be calculated for assessments with assessment reference date before 10/1/2013, because MDS Items used in the calculation are not available. The standard RUG-IV grouper can be used to calculate the FY2013 Medicare transition RUGs for assessments on or after 10/1/2013 by using the Medicare classification parameter for FY2013--by setting the grouper sRehType

ID	Topic	Question	Answer
			parameter to MCAR2 (the FY2013 setting).
20140107-015	K - RUGs	Will the user receive the -1067 message for all assessments with ARDs during the transition window or only those that calculate different RUG scores using MCAR2 and MCAR3? What type of warning message will the user see in the Final Validation report if the submitted RUG does not match the calculated RUG the ASAP system generates?	The Final Validation Report will include an FY2013 Medicare Transition RUG (based on MCAR2) in the -1067 message for all assessments with ARDs during the transition window (10/1/2013 - 10/13/2013), whether or not the transition RUG is the same as the submitted Medicare RUG in Z0100A (based on MCAR3). Using the FY2013 Medicare RUG (based on MCAR2) for submission and billing until ARDs of 10/14/12013 is completely inappropriate. All Medicare Part A days of service beginning with 10/1/2013 must be billed with the FY2014 Medicare RUG (based on MCAR3). If the FY2014 RUG is different than the FY2013 RUG, then an assessment with ARD on or after 10/1/2013 will receive an incorrect RUG warning and a claim for a day of service on or after 10/1/2013 can be rejected for Medicare payment.
20140107-011	K-RUGs	Attached is the current RUG III mapping from the CMS MDS technical web page. We want to make sure we are calculating the therapy days correctly for the states that require a RUG III calculation in Z0200 A. The attached cross walk does not appear to include the new field O0420 in calculating distinct rehab days that is now used for RUG IV. Can you please clarify if this cross walk is still accurate or will a new updated cross walk be posted since the new field was added for RUG IV. Thanks in advance for clarifying.	The RUG-III classification does not use distinct days of therapy (O0420) at all. It is not necessary for that item to be considered in the RUG-III MDS 3.0 to MDS 2.0 crosswalk. The use of O0420 is limited to RUG-IV applied to Medicare.
20140107-012	K - RUGs	In the document: 11139_MDS_3.0_Chapter_6_V1.11_Oct_2013.pdf on pages 6-32 and 6-33 reads as follows: **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied) 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more and At least 5 distinct calendar days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4) ==========	Chapter 6 of the RAI Manual provides information for the **MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)**, as indicated by the chapter title. The October 2013 version of chapter 6 applies to the SNF rules and policies in effect for FY2014. The RUG worksheet in Chapter 6 only applies to the current Medicare SNF RUG classification in effect for FY2014. An earlier version of Chapter 6 and the RUG worksheet for a previous year apply to the Medicare SNF RUG classification in effect for that previous year. In contrast, the standard RUG grouper code (as represented by either the SAS or C++ code) is more

ID	Topic	Question	Answer

		Low Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied):
		1. In the last 7 days:
		Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more
		and
		At least 3 distinct calendar days of any combination of the 3 disciplines
		(O0400A4, plus O0400B4 plus O0400C4)
		and
		Two or more restorative nursing services* received for 6 or more days for at least
		15 minutes a day
		
		However, in the SAS code, the logic is different depending on the sRehabType variable:
		
		*Determine Medium Therapy indicator (l_rehab_medium).;
		l_rehab_medium = 0;
		
		*V1.03.0 CHANGE to accomodate new sRehabType = 'MCAR3';
		
		IF ((sRehabType = 'MCARE' OR sRehabType ='MCAR2' OR sRehabType ='OTHER') AND
		(n_tot_rehab_min >= 150) AND
		(i_tot_rehab_days >= 5))
		THEN l_rehab_medium = 1;
		
		*V1.03.0 CHANGE to include new sRehabType = 'MCAR3';
		
		ELSE IF ((sRehabType = 'MCAR3') AND
		(n_tot_rehab_min >= 150) AND
		(O0420 >= 5))
		THEN l_rehab_medium = 1;
		ELSE IF ((l_Mcare_short_stay = 1) AND
		(n_avg_rehab_min >= 30))
		THEN l_rehab_medium = 1;
		
		*Determine Low Therapy indicator (l_rehab_low).;
		l_rehab_low = 0;
			general and handles Medicare SNF RUG classification for all years since the implementation of MDS 3.0 (FY2011 through FY2014), in addition to non-Medicare classification. The type of classification performed by the grouper is based on the sRehabType parameter as follows:
			
			sRehabType = MCARE for Medicare SNF classification for FY2011
			sRehabType = MCAR2 for Medicare SNF classification for FY2012 and FY2013
			sRehabType = MCARE for Medicare SNF classification for FY2014
			sRehabType = OTHER for non-Medicare classification
			
			If you apply the RUG logic to identical assessments dated before 10/1/2013 (MCAR2) and after 10/01/2013 (MCAR3), you can get different classification results because different Medicare logic is used for these two time periods for accounting days of therapy. This is intended to conform to changed Medicare SNF policy and rules. In addition to the change in accounting days of therapy for Medicare SNF FY2014 classification, there is also a change in the non-oral nourishment logic. Before 10/1/2013, the non-oral nourishment items K0700A and K0700B are used but after 10/1/2013 the new K0710A3 and K0710B3 items are used.

ID	Topic	Question	Answer
		*V1.03.0 CHANGE to accomodate new sRehabType = 'MCAR3'; IF ((sRehabType = 'MCARE' OR sRehabType ='MCAR2' OR sRehabType ='OTHER') AND (n_tot_rehab_min >= 45) AND (i_tot_rehab_days >= 3) AND (i_rnursing_cnt >= 2)) THEN l_rehab_low = 1; ELSE IF ((sRehabType = 'MCAR3') AND (n_tot_rehab_min >= 45) AND (O0420 >= 3) AND (i_rnursing_cnt >= 2)) THEN l_rehab_low = 1; One of our QA representatives noticed a change in the RUG score calculated for identical assessments dated before and after 10/01/2013, I traced the issue down to the MCAR3 logic. We were not able to get the same RUG score by working through the documented worksheet.	
20140107-003	K-RUGs	A submitted MDS was recalculated using RUG IV from a BA160 level to a CA160 level by the QIES system. The ADL score is 0 Hand Calculation is a BA1160 level – unless there was a change made – The question is M1040D, E – - the resident doesn't have M1040 D or E Checked but does have M1200H checked. The D0300 score is 02 The previous MDS for this resident was submitted in Aug 2012 without Recalculation –	The submitted MDS was correctly recalculated by the QIES system. It is true that the resident does not have a qualifier for Clinically Complex, but there are other ways to receive a Clinically Complex classification. The resident has an Extensive Services qualifier (O0100M2 -- Infection Isolation While a Resident). An Extensive Services classification requires a minimum ADL score of 2, so the resident does not qualify for Extensive Services. However a resident with an Extensive Services qualifier and too low an ADL score (in this case 0) qualifies for Clinically Complex instead. This is documented in the RAI Manual on page 6-37 in the text under Step #2. Note that generally a resident classifies as Clinically Complex if there is an Extensive Services, Special Care High, or Special Care Low qualifier AND an ADL score of 0 or 1. The facility should bill the Recalculated A0100A (Medicare HIPPs) provided on the Final Validation Report.
20140107-004	K-RUGs	When we transmit from the state of Georgia we are getting this error (Warning -3616a).	For state RUG calculation 1 (Z0200A), Georgia (GA) has the following parameters set in the ASAP system:

ID	Topic	Question	Answer
		We have checked our Software and GA CMI and based on the information our RUG in Z0200A is correct. Could there possible be a problem? CMI RAC = 1.936 or 1.975 SSB = 1.736 or 1.771 MDS 3.0 Item(s): Z0200A, RECALCULATED_Z0200A Invalid Data Submitted: RAC, SSB Message Number: -3616a WARNING Message: Incorrect HIPPS/RUG Value: The submitted value of the HIPPS/RUG code does not match the value calculated by the QIES ASAP System.	RUG version = RUG III RUG Logic version = 5.20 Urban CMI set code = D01 Rural CMI set Code = D01 Rug Model = 34 group RUG classification = Index maximized Rehab type = Other Please note that a CMI set code will only have 1 value for each RUG group. It is not possible to have SSB and RAC to have multiple values as stated below. For the D01 set code, RAC CMI value = 1.31 SSB CMI value = 1.33. Since the SSB CMI value is greater than the RAC CMI value, the indexed maximized RUG group for these 2 RUG groups is SSB. Please check your software to insure that the RUG parameters are correct if using the CMS supplied RUG DLL. If not using the CMS supplied DLL, please check your software RUG code. If these parameters do not match the ones you understand that you should be using for GA, please contact the state.
20121210-015	K-RUGs	Our QA department found new RUGs in the latest DLL that was sent out: RAE, RAD, RAC, RAB, RAA. And there 72 RUGS, not 66. At first they thought it was a fluke-this is the urban special Medicare in the example, but it appears in other groupers in the RUGS IV groupers. I don't recall hearing about new RUGS. Did I miss something? We are trying to get our programming ready for Oct. and this is a problem.	The CMI sets contain RUG values for ALL models of the RUG. For RUG IV, this includes the 66, 57 and 48 models of the grouper. All CMI sets for the RUG IV grouper contain 72 entries. As a note, all grouper CMI sets for the RUG III grouper (53, 44, and 34 models) contain 58 entries. The CMI values not used for that model have a CMI value of zero (0.00). The CMI value for RAE, RAD, RAC, RAB, RAA in the CMI sets E01, E02, E03 and E04, are zero because these RUG groups are not returned for the 66 group model and CMI sets E01, E02, E03 and E04 are CMI sets for the 66 group model. For code set F01, only RAE, RAD, RAC, RAB and RAA

ID	Topic	Question	Answer
			have CMI values. All of the other rehab groups are zero. This is because the F01 set is for the 48 group model which only uses the rehab groups RAE, RAD, RAC, RAB, RAA. Similarly, looking at the F02 code set used with the 57 group model, the only RU* rehab groups used are RUA, RUB, and RUC and these have CMI values greater than zero. The RUX and RUL rehab groups are not used in the 57 group model have values of zero.
20121210-016	K-RUGs	Does the RUGS DLL version code v1.02.1 replace the RUGS version code 1.0266 for Z100B and Z150B effective as of 7/18/2012?	The Medicare RUG IV logic version continues to be 1.02 with the implementation of the new 1.02.1 code version of the DLL. The Medicare RUG-IV version code (Z0100B and Z0150B) of 1.0266 is not changed with the new DLL. The DLL code version of 1.02.1 continues to use logic version 1.02 and corrects a rare problem that occurred with code version 1.02.0.
20121210-017	K-RUGs	I have an assessment that was accepted, but with a warning. (-3616a) The QIES ASAP system recalculated a submitted score of RHC04 (which is correct by the hierarchical method) with a score of HD2- which is correct as the non-therapy RUG. Why would CMS replace a rehab score with a lower ranking one?	For future issues, you should contact your State Automation coordinator. CMS uses the indexed maximized method not the hierarchical method of RUG calculation. Since CMS uses index maximizing, you should reference the payment rates for each of the RUG categories for the appropriate CMI set. There are several times when the non-Rehab RUG has a higher CMI value. When this is the case, Z0100A will return a non-therapy RUG. If the facility associated with this MDS is classified as urban, then HD2 does have a higher CMI than RHC. If the facility is rural, then RHC has the higher CMI. Please verify that your software is set properly, urban vs rural for the proper CMI and it is using index maximization not hierarchical method.
20121210-018	K-RUGs	Some of our clients are starting to get validation report Warnings for EOT-R assessments and MDS 3.0 item Z0100. In one case we calculated a RHA0A, and it was recalculated to HB10A.	For the assessment provided , the manually calculated RUG (RMB) is the same as the ASAP system or recalculated Z0100 RUG value. Since the submitted Z0100 value of RVB01 did not match the system recalculated RUG, the ASAP system correctly returned the warning error message on the Final Validation Report. To be an RV_ (very high) RUG group, for a non-short stay assessment, 2 criteria must be met (see page 6-34 and 6-35 of the MDS RAI manual).

ID	Topic	Question	Answer
			Total Therapy minutes of 500 minutes or more and At least 1 discipline (O0400A4, O0400B4, O0400C4) for at least 5 days. This record in question had over 500 minutes of therapy, but did not have any discipline for at least 5 days. Both disciplines were for 4 days. The RH_ (high) RUG group for a non-short stay assessment has the same number of days criterion so this assessment did not qualify for the high rehab group. (see page 6-35 of the MDS RAI Manual) To be an RV_ (very high) RUG group, for a non-short stay Please note: The VUT (Validation Utility Tool) does not Recalculate RUG values, which is why no error was returned when the record was run through the tool. The following message displays with the Validation Utility Tool posting on the QTSO website: "The VUT does not currently interface with the RUG III and IV DLLs – therefore, it does not recalculate nor confirm that RUG values are correct."
20121210-019	K - RUGs	There seems to be an issue with the RUG-IV grouper program where it won't recognize an assessment as a RMA RUG-IV Class, instead its returning an error. The assessment in question is an NP PPS 5 day start of therapy short stay assessment. To test this I only used the Speech Therapy - Individual Minutes, set the number of days as 1, set the therapy start date at 5/14/2012 and therapy end date as 5/14/2012, so there is only 1 day on which therapy was performed. I then changed the amount of therapy minutes to see which class it returned. Below are the values I used, a table of the minutes that I used and the values I got back. A2000. Discharge Date: 05/14/12 A2300. Assessment Reference Date: 05/14/12 A2400B. Start date of most recent Medicare stay: 05/10/12	The CMS Medicare RUG calculation uses Index Maximizing. Grouper Error 5 does indicate a Start of Therapy assessment that does not yield a rehab/extensive or rehab classification (group does not start with "R") for the Medicare HIPPS Code in Z0100. With 64 average rehab minutes, the Start of Therapy assessment will qualify for Medium Rehab. However a lower (non-rehab) Medicare classification can occur because of Medicare index maximizing. When a resident qualifies for multiple groups, index maximizing assigns the group with the highest CMI (the highest payment rate). With ADL 4, the RMA group will index maximize to any of the following groups: HB2, HB1, and LB2. If the resident has appropriate qualifiers for any of these groups, then classification will be that group (not RMA) and an Error 5 will be returned by the grouper.

<table>
<tr><th>ID</th><th>Topic</th><th>Question</th><th>Answer</th></tr>
<tr><td></td><td></td><td>A2400C. End date of most recent Medicare stay: 05/14/12

ADL Score: 4

O0400A4. Days: 1
O0400A5. Therapy Start Date: 05/14/12
O0400A6. Therapy End Date: 05/14/12
Individual Minutes
RUG-IV Class Returned
Is this a Medicare Short Stay Assessment?

<table><tr><th>Individual Minutes</th><th>RUG-IV Class Returned</th><th>Is this a Medicare Short Stay Assessment?</th></tr><tr><td>144</td><td>RUA17</td><td>Yes</td></tr><tr><td>100</td><td>RVA17</td><td>Yes</td></tr><tr><td>65</td><td>RHA17</td><td>Yes</td></tr><tr><td>30</td><td>Error: 5</td><td></td></tr><tr><td>15</td><td>Error: 5</td><td></td></tr></table>
The error that is being returned is:

Z0100 A start of therapy OMRA does not result in a Rehabilitation plus Extensive or Rehabilitation group. Error 5

I have gone through the worksheet to calculate the RUG Group and I can't find the reason that it would return a class if the minutes are 65 or higher but will return an error if the minutes are 64 or less. The assessment meets all the requirements for the RUG-IV Group RMA17, so then why is it returning an error?</td><td></td></tr>
<tr><td>20111110-010</td><td>K-RUGs</td><td>For the October 1, 2012 release, I am not finding anywhere in the documentation on the RUG information where it says how to set the sRehabType when using the RUG dll's. Is the following a correct assumption for setting these values:
* If the ARD Date is greater than or equal to 10/1/2011</td><td>Here are locations of documentation concerning "index maximizing":

1. There is an "Index Maximizing" section in Chapter 6 of</td></tr>
</table>

ID	Topic	Question	Answer
		and it is a Medicare assessment then sRehabType = MCAR2 * If the ARD Date is less than or equal to 9/30/2011 and it is a Medicare assessment then the sRehabType = MCARE * If not a Medicare assessment then the RehabType = OTHER	the RAI Users Manual. 2. There is discussion of index maximizing on page 8 of the "RUG-IV grouper overview" document in the RUG-IV package and on page 18 of that document. There is presentation of the standard CMI sets for index maximizing. When setting the DLL sRehabType parameter, the type of assessment does not matter. The setting for this parameter is contingent on the MDS 3.0 RUG item (e.g., Z0100A for normal Medicare RUG) and the assessment reference date (A2300). The rules are: 1. For Z0100A (Medicare RUGs: • sRehabType = 'MCARE' for all assessments (PPS and non-PPS assessments) with assessment reference date before 10/1/2011. • sRehabType = 'MCAR2' for all assessments with assessment reference date of 10/1/2011 or later. • Note that the DLL provides the value for Z0100A in sRugMax and the value for Z0150A (Medicare non-therapy RUG) in sRugMax_NT. 2. For Z0200A and Z0250A (Medicaid RUGs): • sRehabType = 'Other' for all assessments (PPS and non-PPS) for all assessment reference dates.
20111110-011	K-RUGs	I realize that a Short Stay MDS or an SOT MDS will be rejected from the system if the Z0100A data does not begin with an R (for a Rehab group). -3804 FATAL Error. I have an odd situation where a Short Stay MDS RUG score otherwise qualifies for a non-rehab group because of index maximization (CC1 vs. RLA). I believe that this could potentially be the same situation for an SOT assessment. Can you confirm for me that we should not be considering index maximization in this situation for a Short Stay or an SOT MDS?	To qualify as a Medicare Short Stay assessment, the assessment must be an SOT assessment. The difference between a Medicare Short Stay assessment and a non-Short Stay SOT assessment is that the Short Stay assessment uses the average daily minutes of therapy for rehab classification. The non-Short Stay SOT assessment uses the normal total minutes of therapy for rehab classification. In both cases (short stay or other SOT), the indexed maximized Medicare RUG (Z0100A) group must be a

ID	Topic	Question	Answer
			rehab group starting with an "R". Any SOT will be rejected unless the Z0100A value recalculated by the ASAP system using index maximizing is a group starting with "R".
20110803-006	K-RUGs	Assuming the FY2012 rule is approved and the v1.01.1 RUG IV code is implemented on October 1, I have a question regarding the correction for the short stay indicator and the potential for rejected assessments. Will the correction in the Medicare Short Stay Indicator calculation apply to all MDS Assessments regardless of Target Date? Per the code *Set Medicare Short Stay Indicator (l_Mcare_short_stay); /*V1.01.1 CHANGES: 1. A03100C must = '1' rather than '1' or '3'; 2. sRehabType can = "MCARE' or "MCAR2' rather than just "MCARE' There are 2 potential scenarios that are of concern 1. If the assessment where A0310C = [3] is completed prior to the October 2011 implementation, it could calculate the Short Stay Indicator = [1] utilizing the v1.00.9 code. This could result in a valid RUG calculation where the first letter is R due to the special Medicare short stay calculation. If the submission file is submitted on October 1, 2011, will the RUG group be recalculated using the v1.01.0 code and the assessment be rejected? 2. It appears that a Modification could be rejected, if the assessment is a Modification with the original assessment A0310C = [3] that was accepted prior to October 1. The Short Stay Indicator = [1] AND resulted in a RUG calculation with where the first letter is R due to the special Medicare short stay calculation. If the Modification is created on or after October 1, 2011, the v1.01.1 calculation will return the Short Stay Indicator = [0] AND the default AAA RUG calculation. Note: Version 1.02.0 of the MDS 3.0 Data Specifications will be implemented in October, 2011. This final version has been updated with the errata from version 1.01.1	The change in the Medicare Short Stay assessment indicator logic with RUG-IV V1.01.1 only affects whether the short stay indicator is set and not whether an assessment is accepted or rejected by the ASAP system. The short stay logic change is to only set the indicator if A0310C = 1 (SOT OMRA) rather than if A0310C = 1 (SOT OMRA) or 3 (SOT and EOT OMRA). Actually, this coding change has NO impact on whether the indicator is set or not. Other requirements for a short stay assessment are: 4. The Medicare Part A covered stay must end on the assessment reference date (A2300) of the Start of Therapy OMRA. That assessment reference date must equal the end of Medicare stay date (A2400C). 6. Rehabilitation therapy must not have ended before the last day of the Medicare Part A covered stay. That is, at least one of the therapy disciplines must have a dash-filled end of therapy date (O0400A6, O0400B6, or O0400C6) indicating on-going therapy or an end of therapy date equal to the end of covered Medicare stay date (A2400C). These 2 requirements, taken together, mean that all therapy has not ended on the assessment ARD for an assessment to qualify for short stay. However, an EOT OMRA has an ARD 1 to 3 days after the last day that therapy was received and cannot meet these two requirements. An EOT OMRA can never qualify as short stay, and some developers had been confused by logic allowing A0310C to equal 3 for a short stay. To avoid this confusion the logic change was made in V1.01.1 that

ID	Topic	Question	Answer
			A0310C must only equal 1 to qualify for short stay.
20110803-008	K-RUGs	For the states that use RUG-IV in Z0200 and/or Z0250 and have set up the RUG-IV score validate in the ASAP System, we will need to know the correct RUG-IV version that is being validated in Z0200B and Z0250B: As of Assessment ARD of 10/1/2011 what is the ASAP System expected State (Z0200B/Z0250B) RUG-IV version?	The ASAP system uses the current RUG IV for all calls (both CMS and state) sending the appropriate parameters based on the target date of the record and the CMS and state requirements. The version values for the RUG IV grouper that are compared to the B RUG item are: 1.0166 1.0157 1.0148
20101220-014	K-RUGs	What are the parameters for calculating the Medicare RUG/HIPPS value on an MDS 3.0 assessment from a swing bed?	**RUG-IV Specifications and DLL Package (V1.02.0)** is located on the CMS MDS 3.0 Technical website http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html The download is RUG III files & RUG IV files. The RUGIV grouper overview in this download explains the calling the RUG dll. The RUGIV DLL user doc explains each parameter.
20101220-016	K-RUGs	Where do I find the RUG version code to submit in Z0100B, Z0200B and Z0250B?	The RUG version code required in the submission record is calculated and returned by the RUG-III or RUG-IV grouper, either the .dll or the SAS code in both cases. This information is found in the RUG specifications for the particular RUG system being used. This version is dependent on the RUG system (RUG III or RUG IV) and the model within a system (number of groups used). Z0100B and Z0150B: The first 3 characters of Z0100A and Z0150A are always a Medicare RUG-IV group code and the corresponding version code in Z0100B and Z0150B is "1.0066" as CMS uses the 66-group model. Z0200B and Z0250B: The RUG group reported in Z0200A and Z0250A can be RUG-III or RUG-IV as required by the specific state. If the state is using RUG-III, then the version code in Z0200B or Z0250B is "07" for the 44-group model, "08" for the 34-group model, and "09" for the 53-group model. If the state is using RUG-IV, then the version code in Z0200B or Z0250B is "1.0066"

ID	Topic	Question	Answer
			for the 66-group model, "1.0057" for the 57-group model, and "1.0048" for the 48-group model.
20101101-024	K - RUGS	My state is not having me submit Medicaid RUGs in Z0200 nor Z0250. Do I need to submit those items in my XML file?	The Medicaid RUGs items Z0200A, Z0200B, Z0250A and Z0250B are always active on NC, NQ, and NP assessments. As active items, these items must be included in your XML file with valid values. Per the MDS 3.0 Data Specifications, the valid values for these items are "TEXT" or "^". If the state requires the Medicaid RUGs item to be submitted, then the item value should be the appropriate RUG TEXT value. If the state does not require the Medicaid RUGs item to be submitted, then the item value should be a "^" (blank).
20101101-023	K - RUGS	What versions of the RUG DLLs should we use?	The most current versions should be used. The RUG documentation and DLLs are posted on the MDS 3.0 Technical website. Please check this site frequently for updates
20101101-020	K - RUGS	The distinction for rural and urban, is urban over 10,000?	To distinguish between rural and urban you must use OMB's Core-Based Statistical Area (CBSA) definition. Facilities that are geographically located in a CBSA are urban, those outside of a CBSA are non-urban or considered rural (this includes Micropolitan Areas). CBSA's are established on a county level.
20101101-017	K - RUGS	Could you explain the ASAP setups for the state with regards to validation of the state RUGs? Are the state options to validate or not validate or is there an option to validate if data is present? If a facility submits a RUG in Z0200 or Z0250 and the state does not require submission does the ASAP RUG validation run based on the state setups in the ASAP system or does it run based on the presence of data.	The ASAP system will validate the Medicaid RUG items (Z0200 and Z0250) on NC, NQ and NP ISCs if the state has set up the options to do the evaluation in the MDS 3.0 DMS. If a facility submits a RUG in Z0200 and/or Z0250 and the state does not require submission based on the state setups in the ASAP system, then the ASAP system does not recalculate these values. Regardless of the flag, all "submitted items" are always saved as long as they are active for the ISC, and the assessment is accepted. For NC, NQ, and NP, items Z0200 and Z0250A are active so the submitted values are stored in the database regardless of whether the recalculation is done.
20100926-041	K - RUGs	Do we have a misunderstanding of the MDS 3.0 to RUG III regulations? It was our understanding that the states are not permitted to alter the RUG III crosswalk or code. We have just been notified by the State of Maine that they are going to	CMS does not dictate to States how to calculate their State reimbursement methodology or payment rates, including payment for Medicaid residents in a long term care stay in a nursing home. Since this is a "non-standard" use of the

ID	Topic	Question	Answer
		create a hybrid RUG III calculation code for the state.	RUG calculation, the ASAP system will not recalculate the state Medicaid RUG (Z0200). Maine will have to do all recalculations on their own state Medicaid system. The current MDS 2.0 Medicaid RUG calculation settings for Maine have the "Calculate Medicaid RUG option" set to Y, but there are no RUG calculations entered, so the MDS 2.0 state system does not recalculate RUGs for Maine on the MDS 2.0 assessments.
20100926-040	K - RUGs	The RUG III mapping specs do not include a translation from MDS 2.0 I1cc Traumatic Brain Injury to MDS 3.0 I5500 Traumatic Brain Injury. Is there a reason this no longer is used in RUG III calculation?	The MDS 2.0 item I1cc (Traumatic Brain Injury) is not used by the RUG-III grouper. It is therefore not necessary to include a translation between I5500 and I1cc in the RUG-III mapping specs.
20100926-039	K - RUGs	If facilities performs an OMRA start of therapy PPS for a resident and that resident qualifies for multiple RUG scores (some rehab and some non rehab) after applying the CMI index maximizing logic the resident RUG score ends up being a non rehab score. After that we apply the logic that states that if the user is performing a OMRA start of therapy and a non rehab RUG score is achieved then we are to assign a default AAA RUG score. This issue is prevalent when the resident qualifies for a non rehab RUG that has a higher index value such as ES3 vs. RML, RHL, or RLX (assuming a Rural E01 CMI) Can you provide some clarification on what is desired in this case?	The requirement is that a start of therapy OMRA must produced a Medicare index maximized RUG-IV classification in a rehabilitation plus extensive group or a rehabilitation group. This means that the Medicare classification in Z0100A must be a rehabilitation plus extensive group or a rehabilitation group. That classification is based on the 66-group model, the Medicare rehabilitation classification type, and the appropriate Medicare CMI set (E01 for rural and E02 for urban). If the Z0100A RUG-IV classification is a group below the rehabilitation category, then the record will be rejected by the CMS MDS 3.0 system.
20100926-038	K - RUGs	Our vendor members are in need of a decisive algorithm for the second digit of the HIPPS AI code (character 5 of the HIPPS code that contains the RUG rates in Z0100A and Z0150A) that accounts for all potential combinations of the assessment type fields (A0310A – A0310F). Many combinations of the A0130 fields are going to fall through this logic and get an “X”. If the B or F value is changed, the algorithm doesn’t work. Our vendor members would appreciate CMS’ recommendation on the criteria that produce a valid second digit of the HIPPS AI code. We appreciate your hard work and prompt response.	A decisive algorithm for the AI code is contained in the RUG-IV SAS code and the RUG-IV C++ code provided in the RUG-IV grouper package. The DLL in that package implements this algorithm. Note that there is no AI code for all combinations of the reason for assessment fields (A0310A - A0310F). A RUG code and an AI code are not computed for discharge or entry records. Also, all other combinations of A0310A - A0310F are not valid. Please consult the data submission specifications for the valid combinations. The AI logic will not work with an invalid combination.

ID	Topic	Question	Answer
			SUMMARY The AI code definition in Chapter 6 will allow correct determination of the AI code for all appropriate assessments.
20100926-037	K - RUGs	The NO, NS, NOD, and NSD forms do not have all of the RUG III, 5.20, 34 grouper RUG items. Do these forms have all of the RUG IV items?	OMRA assessments (NO, NOD, NS, and NSD) do not support calculation of RUG-III. The RUG-III/MDS 3.0 crosswalk logic explicitly states this. If an OMRA assessment is run through the RUG-III/MDS 3.0 crosswalk, the MDS 2.0 record that is produced will not support RUG-III. If this MDS 2.0 record is run through the RUG-III grouper, the grouper will not compute a RUG-III group. The reason that OMRA assessments do not support RUG-III is that they are to be used only for RUG-IV, SNF PPS purposes. The RUG-IV grouper does produce RUG-IV groups for NO, NOD, NS, and NSD. Start-of-therapy OMRAs (NS and NSD) are valid only if they produce a rehabilitation or rehabilitation-plus-extensive RUG-IV group. NS and NSD therefore do not contain all of the RUG-IV items. Instead they contain only those RUG-IV items that are required to produce rehabilitation or rehabilitation-plus-extensive RUG-IV groups. NO and NOD assessments, in contrast, contain the complete set of RUG-IV items and can produce any of the RUG-IV groups (including non-rehabilitation groups).
20100926-035	K - RUGs	We have a scenario in which we need clarification. A0310A = 99 A0310B = 07 A0310C = 1 We have a code for Z0100A = RMA02 But for the Non-Therapy calculation (Z0150A) we have hit a default rug condition (AAA) and so our value being calculated for Z0150A = AAA02. It is our understanding that if the RUG-IV group is AAA (default), then the AI code should be reset to 00. The v1.00.8 SAS code provided does this perfectly if	A non-therapy RUG classification is not possible on a stand-alone start of therapy OMRA, because almost all of the items necessary for non-therapy classification are inactive. The grouper sets the non-therapy RUG group to AAA for a stand-alone start of therapy OMRA. However it does not adjust the AI-code. The AI-code describes the type of assessment based on reasons for assessment with a code of 02 for a standalone start of therapy OMRA. As a result, the non-therapy HIPPS code for a stand-alone start of therapy OMRA is AAA02. The "02" allows identification of the reason for the AAA group code. The other cases where the HIPPS code contains an AAA classification are: AAA (with a blank AI-code) -- when a grouper parameter is in error

ID	Topic	Question	Answer
		the Medicare Part A RUG-IV group is AAA, but doesn't seem to do the same for the NT calculation. The NT calculated group is set in a variable sRugHier_NT not in sRugHier. Is there supposed to be only one AI calculation that gets set as part of both Z0100A and Z0150A (as we have currently), or should the code be independent and have separate reset conditions for each calculation?	AAAX -- when the type of record does not support RUG classification (e.g. entry record) or there the combination of reasons for assessment is invalid. . AAA00 -- normal and non-therapy RUG for any start of therapy OMRA where the normal RUG was below the rehab groups AAA02 -- non-therapy RUG for a standalone start of therapy OMRA where the normal RUG was a rehab/extensive or rehab group AAA07 -- non-therapy RUG for a Medicare short stay assessment where the normal RUG was a rehab/extensive or rehab group It is useful to retain information concerning the cause for an AAA classification, rather than always resetting the AI-code 00 for any AAA classification.
20100926-030	K - RUGs	I have the returned data from the RUG calculations and would like to know what returned calc values are used to populate all the Z fields: Z0100a,b,c, Z0150a,b, Z0200a,b, Z0250a,b and Z0300a,b. I do understand that the RUG code returned and the AI code are combined and placed in the fields. I just don't know which one.	The RUG IV documentation located on the CMS technical website: http://www.cms.gov/nursinghomequalityinits/30_nhqimds30technicalinformation.asp explains the RUG IV calculations. The following relates the parameters returned by the RUG IV code to the items on the MDS 3.0 item set. Medicare (RUG IV) returned grouper items when RUG IV call did not return an error. Z0100A = sRugMax concatenated with sAI_code Z0100B = sRugsVersion FYI - Only current value for Medicare is "100-66" Z0100C = I_Mcare_short_stay If A0310C = 1 or 3, then if the first character of C_MDCR_HIPPS_TXT is not equal 'R', then the SOT assessment did not produce the required rehab group. Z0150A = sRugMax_NT concatenated with sAI_code Z0150B = sRugsVersion State Medicaid (RUG III or RUG IV per state option) returned grouper items when RUG III call did not return an error.

ID	Topic	Question	Answer
			RUG IV MDS_RUG_CLSFCTN_TYPE_CD = INDEX Z0200A or Z0250B = sRugMax Z0200B or Z0250B = sRugsVersion If MDS_RUG_CLSFCTN_TYPE_CD = HIER Z0200A or Z0250A = sRugHier Z0200B or Z0250B = sRugsVersion RUG III If MDS_RUG_CLSFCTN_TYPE_CD = INDEX Z0200A or Z0250A = cRugMax Z0200B or Z0250B = cRugVersion If MDS_RUG_CLSFCTN_TYPE_CD = HIER Z0200A or Z0250A = cRugHier Z0200B or Z0250B = cRugVersion
20100820-047	K - RUGS	I could not answer the question about “calculations for 66 groups which is translated easily to the 57 group but not to the 48 group”	Currently, the only documentation for the RUG-IV 48 and 57 group models is in the RUG-IV SAS code and C++ code in the Grouper Package. Here is a quick description. 57-Group Model. To achieve the 57 group models: 1. Simply leave out the 9 Rehabilitation/Extensive groups from the 66-group model. 2. Begin classification with the Ultra High Rehab category 3. Proceed with Extensive Services and the lower classifications in the normal way. 48-Group Model. To achieve the 48-group model: 1. Leave out the 9 Rehabilitation/Extensive and the following 14 Rehabilitation groups from the 66-group model. 2. Start with the Extensive Services groups. 3. After the Extensive Services groups, check to see if the resident would qualify for the 66-group Medium or Low Rehabilitation categories as follows: a. If total therapy minutes (across Speech, OT and PT) are greater than or equal to 150 and the total days of therapy (across Speech, OT and PT) are greater than or equal to 5 OR b. If total therapy minutes (across Speech, OT and PT) are greater than or equal to 45 and 2 or more restorative nursing services received for 6 or more days. If either a or b is true, then the resident qualifies for a

ID	Topic	Question	Answer
			48-group Rehabilitation group based on ADL score as follows: RAE if ADL score is 15-16. RAD if ADL score is 11-14. RAC if ADL score is 6-10. RAB if ADL score is 2-5. RAA if ADL score is 0-1. 4. Proceed with Special Care High and the lower classifications in the normal way. Note that the 57-group classification for RUG-IV mirrors the 44-group classification for RUG-III and the 48-group classification for RUG-IV mirrors the 34-group classification for RUG-III. There are classification worksheets for the RUG-III 34- and 44-group models at: http://www.cms.gov/MDS20SWSpecs/12_RUG-IIIVersion5.asp#TopOfPage
20100820-043	K - RUGS	Do you happen to know where you can determine what type of rehab should be used when figuring the RUG IV? That parameter is passed in and it is expected to be other or mcare, but I do not see where this value is specified in MDS 3.0. Since they are doing the Z0100A and Z0150A does that mean that passing in the RehabType to the RUG dll's is obsolete, since when using RUG IV you get the Medicare Rate and the Non-Therapy Rate?	For Medicare calculations, the ASAP system always sets the rehab type to MCARE for FY2011 (October 1, 2010 – September 30, 2011) MCAR2 for FY2012 and FY2013 (October 1, 2011 – September 30, 2013) MCAR3 for FY2014 (October 1, 2014 – until changed)
20100820-027	K - RUGS	Please clarify the calculation of the sRUGHier_NT, when the assessment is a SOT or SOT/EOT not combined with OBRA or other PPS. However, I would expect that the Non-Therapy RUG would be a nursing RUG to allow for the billable days outside of the therapy date range. Specifically, I would expect the SOT to provide a nursing RUG for the days prior to start of therapy and the EOT to provide a nursing RUG for the days after therapy. The RUG IV v1.00.6 section Adjustment in RUG group for a start of therapy OMRA (A0310C = 1 or 3), per the code If start of therapy OMRA gives a 66-group index maximized Rehabilitation Plus Extensive Services or a Rehabilitation Group and is not combined with OBRA or other PPS assessment then reset all non-therapy RUG results to the AAA default group.	A start of therapy assessment cannot be used to establish a non-therapy RUG for billing the days prior to start of therapy. SNF PPS Policy is that a start of therapy OMRA only influences billing from the start of therapy services forward. The days prior to the start of therapy must be billed based upon another PPS assessment that established a billing rate for those prior days. This other assessment may be combined with the start of therapy OMRA. If there is no other PPS assessment establishing a billing rate for those prior days, then those days cannot be billed. Given this policy, it is appropriate that the RUG-IV grouper set the non-therapy RUG classification for a stand-alone start of therapy OMRA (not combined with another OBRA or PPS assessment) to the AAA default group. An end of therapy OMRA establishes a non-therapy RUG for billing days starting with the day after therapy ended. A

ID	Topic	Question	Answer

		"ELSE IF ((A0310A = '99') AND
		((A0310B = '99') OR (A0310B = '07')) AND
		(A0310D NOT = '1'))
		THEN DO;
		sRUGHier_NT = 'AAA';
		nRugHier_NT = 72;
		sRUGMax_NT = 'AAA';
		nRUGMax_NT = 72;
		
		So when the following is true:
		A0200 = 1
		A0310A = 99
		A0310B = 07
		A0310C = 1
		A0310D = ^
		
		AND the normal RUG result is [R], it appears that the code requires the non-therapy RUG to be AAA when it should be a 66-Group code that is NOT [R].
			non-therapy RUG is therefore necessary for an end of therapy OMRA. For an end of therapy OMRA combined with a start of therapy OMRA, the Rehabilitation/Extensive or Rehabilitation classification is needed to bill days from the start of therapy date through the last day of therapy and the non-therapy RUG is needed to bill from the day after therapy ended forward. Version 1.00.6 of the RUG-IV grouper (the last public version) inappropriately sets the non-therapy RUG to the AAA default group for a start of therapy OMRA combined with an end of therapy OMRA. In this case, the non-therapy RUG is needed for the end of therapy OMRA billing of days after therapy ended. Version 1.00.8 corrects this problem and does not reset the non-therapy RUG to the AAA default group for a start of therapy OMRA combined with an end of therapy OMRA.

20100820-023	K - RUGS	Are there RUG test files?	RUG test files are available in the RUGIII files & RUGIV files download on the CMS MDS 3.0 Technical Information website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html .
20100820-022	K - RUGS	Is there SAS code on the CMS site for this conversion?	There is no SAS code for the conversion of MDS 3.0 items to the MDS 2.0 items needed for RUG-III. However there is a "RUG-III MDS 3.0 Mapping Specifications document that includes a "Logic" section for each MDS 2.0 RUG-III item. This "Logic" is actually tested Visual Basic code and one should be able to convert this to SAS code. This document is available from the CMS MDS 3.0 Technical Information website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html .
20100820-019	K - RUGS	How would we calculate PA RUG score using CMSs supplied DLLs since they are using the RUG III 5.12 44 grouper calculation? Would we use the RUGIII converter and then the 5.12 DLL or the 5.20 DLL? For MDS 2.0, we used our own calculator to come up with the score, but for the new	Use the 5.20 DLL. There is no DLL for the 5.12 version. Using the 5.20 DLL should not lead to different 44-group classifications than your custom 5.12 version application, as long as your custom application strictly mirrored the logic in the CMS 5.12 version code.

ID	Topic	Question	Answer
		MDS 3.0, we are trying to make it a little easier on ourselves.	Please note that the CMI array has 49 elements for 5.12 but 58 elements for 5.20 (the additional 9 elements corresponding to the additional 9 Rehabilitation/Extensive groups added with the 53-group model).
20100720-027	K - RUGS	Am I correct that Z0100A is always populated and that when Z0100A represents a non-therapy code that code will also appear in Z0150A, but when Z0100A represents a therapy RUGS code Z0150A will be populated with a non-therapy RUGS, ignoring the therapies used to calculate the therapy RUGS in Z0100A.	This assumption is correct. Z0100A always contains the normal Medicare HIPPS code including a normal RUG code (can be therapy or non-therapy group). Z0150A always contains a Medicare HIPPS code restricted to non-therapy groups (classification made discounting any therapy). Note that these values are expected on OBRA assessments in addition to PPS assessments. In some cases, an OBRA assessment can be used for Medicare PPS billing (when Part A coverage was not initially known). Also, there may be cases where both the normal HIPPS code (Z0100A) and the non-therapy HIPPS code (Z0150A) from the same assessment are both used for Medicare billing. This can happen if a PPS 5-day assessment is combined with an end of therapy OMRA. In this case the normal HIPPS code (Z0100A) is billed for day-1 through the day that all therapy ended and the non-therapy HIPPS code (Z0150A) is billed starting on the day after all therapy ended. See the AI coding section in Chapter 6 of the RAI manual or the SNF provider manual for more detail.
20100720-026	K - RUGS	The spec for the 2nd digit of the HIPPS AI code on page 6-9 of the RAI manual seems to allow for many assessment type combinations to fall through the logic without qualifying for any of the listed code values. An example of section A values that result in this, as I understand it, is listed below: A0200 = 1 A0310A = 01 A0310B = 01 A0310C = 0 A0310D = ^ A0310F = 99 Can you please indicate what the code should be for the second digit of the HIPPS AI code for the above assessment type combination, and why?	The example given is for a nursing home (A0200 = 1) OBRA admission assessment (A0310A = 01) combined with a 5-day PPS assessment (A0310B = 01) and no OMRA assessment (A0310C = 0). The first AI digit indicates the type of PPS scheduled assessment and will be a 1 since this is a 5-day assessment (see Table 2 on Page 6-8 – Chapter 6 of the MDS 3.0 RAI Manual). The entry for the second AI digit indicates if the assessment is an unscheduled PPS assessment or an unscheduled OBRA assessment used for PPS. As indicated on Page 6-8, the unscheduled PPS assessments are the OMRA assessments (indicated by A0310C = 1,2,3). The unscheduled OBRA assessments used for

ID	Topic	Question	Answer
			PPS are the significant change assessment (indicated by A0310A = 04) and significant correction of prior comprehensive (indicated by A0310A = 05). Since this assessment is a scheduled PPS assessment but not also an unscheduled PPS assessment or unscheduled OBRA assessment used for PPS, the second AI digit will be 0, as stated in the first row of Table 3 on Page 6-9:"Scheduled PPS assessment not replaced or combined with an unscheduled PPS assessment or OBRA assessment used for PPS". The only time that the second AI digit will not be 0 is when the assessment is a PPS OMRA, OBRA significant change, or OBRA significant correction of prior comprehensive.
20100114-036	K - RUGS	Will both RUG III and RUG IV systems need to be maintained for a period of time once RUG IV is in place?	The QIES MDS 3.0 ASAP System will support the current RUG-IV Version for both Medicare and Medicaid and RUG-III version 5.20 for Medicaid. States have the option to remain with RUG-III classification and RUG-III will be a permanent feature of the MDS 3.0 system.
20131118-001	L – ASAP	What is the sort order for submitted records?	The sort orders for the submitted records and the facility Final Validation Report have been updated since 2010. We are removing question 20101220-020 and replacing it with this question. The current ASAP sort order for submitted records is as follows: State code (STATE_CD) ascending. Facility internal ID ascending. Target date (TARGET_DATE) when X0100 = 1 or Attestation date (X1100E) when X0100 = 2, 3 ascending. **Trans_type_cd (X0100) - '1' first, then '2' then '3'** Entry/discharge code (A0310F) (‘01’ values first, ‘10’, ‘11’ or ‘12’ values last and all other codes (‘99’) will come in between). Correction number (X0800) ascending. The current sort order for the facility's FVR records is as follows: Last Name

ID	Topic	Question	Answer
			First Name Submission Processing Order MDS_ASMT_ID Fatal errors then warning errors Item in error with Fatal or warning
20140107-018	L – ASAP	There are several changes for the October 2013 release that appear to be required by 9-15-2013. Specifically: -Edit 3851 - [V1.13.0]-New edit. This edit replaces Edit -3573 for all records submitted on or after 09/15/2013. -The “T” (test) value for PRODN_TEST_CD was removed which means that beginning 09/15/2013 test records will no longer be accepted by the ASAP system. The effective date for the data specs is October 1 yet it appears that some things will be expected to be done or ready by September 15. So is the October 2013 software needing to be in place by September 15?	Version 1.13.1 of the data submission specs needs to be in place as of October 1, 2013 and will be applied to MDS records with target date on or after October 1 (target date = assessment reference date for assessments, entry date for entry tracking records, and discharge date for death in facility records). The ASAP system update for Version 1.13.1 will be installed on September 15, 2013. There are only 2 provisions that will be effective as of the September 15, 2013 implementation: 1. Test records will no longer be processed regardless of target date (the PRODN_TEST_CD can no longer = "T" indicating a test record. There is no need to implement Version 1.13.1 earlier than 10/1/2013 for this change. Test records will simply be rejected starting 9/15/2013. 2. A new edit -3851 replaces Edit -3573 in the prior specs versions. These are involved edits checking the sequence of a number of dates on the MDS record. The new edit fixes a problem in the handling of the prior record date (A2200) for a significant correction assessment. The previous edit did not allow a significant correction assessment to be accepted if a reentry intervened between the prior assessment and the significant correction assessment. Edit -3851 fixes that problem. Any record that will pass the prior edit should also pass the new edit. There is no need to implement Version 1.13.1 earlier than 10/1/2013 for this correction.
20101220-018	L-ASAP	What characters will be accepted in the file name.	Only printable ASCII characters, except apostrophes are accepted in the file name. Do not use an apostrophe as a character within file name.
20100225-055	L - ASAP	What resident matching algorithm will be used?	The same resident matching algorithm as is used for MDS 2.0, OASIS, MDS Swing Bed 2.0, and IRF-PAI assessment collection.
20100926-046	L – ASAP	What happens when extra items (XML tags) are sent in the XML submission file?	Extra items that are sent in an XML file but are not active on that ISC will be ignored. They are not edited, not stored, and will not be in the state assessment extract file

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			for that record. No errors messages are sent about any ignored field.
20101101-034	M - Browser	Providers have been prevented from uploading their MDS 3.0 files. Instead of a successful upload, they are receiving the following message: "Upload file name is not in the correct format. Browse for the file and upload again." The users are using IE 7 and their TLS 1.0 is on.	To correct the issue, IE settings should be changed as follows: Select Tools->Internet Options Select the Security tab Select Custom Level... button Locate the setting for "Include local directory path when uploading files to the server" The Disable option will cause a problem, so it should be enabled.
20140107-005	N - QMs	I ran the following Quality Measure reports for my facility and believe that some residents should not have triggered for the following measures: Report Period: 7/01/12 – 10/31/12 Run Date: 11/07/12 Measures in Question: Falls Catheter Inserted and Left in Resident IDs: (1) xxx, (2) yyy, (3) zzz, (4) www Expectation: (1) Should not have triggered for Falls. (2), (3), (4) Should have triggered for Catheter Inserted and Left in	We have investigated the four cases that you described and found no problems with the reports: Case 1: Target assessment date = 8/16/2012, and there was a fall reported on the assessment with target date 11/24/2011. This is a difference of 266 days, and so is just within the lookback period which is 275 days. Case 2: Day 101 of the resident's stay is 1/2/2013, so they're a short-stay resident on the report. This resident is therefore not included in the long-stay measures. Case 3: Day 101 of the resident's stay is 12/23/2012, so they're a short-stay resident on the report. This resident is therefore not included in the long-stay measures. Case 4: The resident did have H0100A = '1' on the target assessment, but is excluded from the measure due to a value of '1' for I1650.
20140107-006	N - QMs	The resident age calculation specification on page F-3 of the http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30-QM-Manual-Appendix-F-Facility-Characteristics-Report-V10.pdf appears to be wrong: **Age** **Calculation of Age, based on Items A0900 (Birth Date) and A2300 (Assessment Reference Date ARD):**	The resident age calculation specification on page F-3 of Appendix F to the QM Users Manual is: IF (MONTH(A0900) > MONTH(A2300)) OR (MONTH(A0900) = MONTH(A2300) AND DAY(A0900) >= DAY(A2300)) THEN Age = YEAR(A2300)-YEAR(A0900) ELSE Age = YEAR(A2300)-YEAR(A0900)-1 This specification is incorrect, with the order of A0900 (birthdate) and A2300 (assessment reference date) in the

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		IF (MONTH(A0900) > MONTH(A2300)) OR (MONTH(A0900) = MONTH(A2300) AND DAY(A0900) >= DAY(A2300)) THEN Age = YEAR(A2300)-YEAR(A0900) ELSE Age = YEAR(A2300)-YEAR(A0900)-1
		
		The condition is correct, but the resulting age calculations should be flipped, as such:
		
		Age
		Calculation of Age, based on Items A0900 (Birth Date) and A2300 (Assessment Reference Date ARD):
		IF (MONTH(A0900) > MONTH(A2300)) OR (MONTH(A0900) = MONTH(A2300) AND DAY(A0900) >= DAY(A2300)) THEN Age = YEAR(A2300)-YEAR(A0900)-1 ELSE Age = YEAR(A2300)-YEAR(A0900)
			IF clause being reversed. The correct specification is:
			
			IF (MONTH(A2300) > MONTH(A0900)) OR (MONTH(A2300) = MONTH(A0900) AND DAY(A2300) >= DAY(A0900)) THEN Age = YEAR(A2300)-YEAR(A0900) ELSE Age = YEAR(A2300)-YEAR(A0900)-1
			
			Appendix F will be corrected. Please note that the actual age calculation in CMS systems is correct. The error is only in the documentation for that calculation.

20121210-001	–N-QMs	I am trying to help a facility troubleshoot an issue where a resident doesn't trigger for Prevalence of Falls on their MDS 3.0 Resident Level Quality Measure Report as they think it should (Facility ID 35403). I used the report dates the facility gave me as 02/01/2012 to 07/31/2012 and the resident (for resident ID 21755645) doesn't trigger unless I run the same report using the default dates of 04/01/2012 and 09/30/2012. The only difference I can see is where the values for A0310A (for OBRA Assessments) fell in the range of qualifying RFAs for the default dates 04/01/2012 and 09/30/2012 while didn't between dates 02/01/2012 to 07/31/2012. The facility completed PPS only assessments within the report dates 02/01/2012 to 07/31/2012 where J1800 = 1. I looked at the QM Manual at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V60.pdf and see on page 7 that the qualifying RFAs are: Qualifying RFAs A0310A = [01, 02, 03, 04, 05, 06] or A0310B = [01, 02, 03, 04, 05, 06] or	The resident that you wrote about had an admission date of 5/1/2012. Residents are classified as short-stay or long-stay depending upon the number of days they resided in the facility as of the report's ending date. Residents with 100 or fewer days are classified as short-stay, while residents with 101 or more days are classified as long-stay. This resident would have reached their 101st day on 8/9/2012. This means that when you ran the report ending 7/31/2012, they were still classified as short-stay and were therefore not included in the long-stay falls measure. When you ran the report ending on 9/30/2012, they would have been classified as long-stay and would therefore have been included in the measure. If you have questions about the details of how residents are classified as long- or short-stay, please refer to page 1 of the current QM User's Manual (version 6). Please let us know if you still have questions about this.

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		A0310F = [10, 11] It seems like this measure is not calculating for the look-back scan when A0310B = [01, 02, 03, 04, 05, 06] and A0310A is not = [01, 02, 03, 04, 05, 06].	