5101:3-3-43.1 Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0).

(A) As used in this rule:

(1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case-mix unit.

(2) "Case mix report" is a report generated by the Ohio department of job and family services (ODJFS) and distributed to the provider on the status of all MDS 2.0 assessment data that pertains to the calculation of a quarterly, semiannual or annual facility average case mix score.

(3) "Comprehensive assessment" means an assessment that includes completion of not only the MDS 2.0 designated for use in Ohio but also completion of the resident assessment triggers, the resident assessment protocols (RAPs), and the resident assessment protocols summary form.

(4) "Critical elements" are data items from a resident's MDS 2.0 that ODJFS verifies prior to determining a resident's resource utilization group, version III (RUG III) class.

(5) "Critical errors" are errors in the MDS 2.0 critical elements that prevent ODJFS from determining the resident's RUG III classification.

(6) "Default group" is RUG III group forty-five, the case mix group assigned to residents with MDS 2.0 records with inconsistent date fields, missing, incomplete, out of range or inaccurate data, including inaccurate resident identifiers any of which precludes grouping the record into RUG III groups one through forty-four.

(7) "Encoded," when used with reference to a record, means that the record has been recorded in electronic format. The record must be encoded in accordance with the United States centers for medicare and medicaid services (CMS) uniform data submission document and state specifications.

(8) "Filing date" is the deadline for submission of the NF's MDS 2.0 assessment data that will be used to calculate the preliminary facility quarterly average case mix score. The filing date is the fifteenth calendar day following the reporting period end date (RPED).

(9) "Locked" means a record has been accepted into the state database.
(10) "MDS 2.0 correction request form" (CRF) is the mechanism used to request correction of error(s), to identify the inaccurate record and to attest to the correction request. A correction request can be made to either modify or inactivate an MDS 2.0 assessment record or an MDS 2.0 discharge or reentry tracking form that has been previously accepted into the state MDS 2.0 database.

(11) "Medicare required assessment" means the MDS 2.0 specified for use in Ohio that is required only for facilities participating in the medicare prospective payment system but does not include the triggers, RAPs, and RAP summary form.

(12) "Quarterly facility average total case mix score" is the facility average case mix score based on both medicaid and non-medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(1) of rule 5101:3-3-43.3 of the Administrative Code.

(13) "Quarterly facility average medicaid case mix score" is the facility average case mix score based on only medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(2) of rule 5101:3-3-43.3 of the Administrative Code.

(14) "Quarterly review assessment" means an assessment that is normally conducted no less than once every three months using the MDS 2.0 designated for use in Ohio that does not include the triggers, RAPs, and RAP summary form.

(15) "Record" means a resident's encoded MDS 2.0 assessment as described in paragraphs (B)(1) to (B)(5) of this rule.

(16) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix group versus another, indicating the relative amount and cost of staff time required on average for defined worker classifications to care for residents in a single case mix group. The methodology for calculating relative resource weights is described in paragraph (H) of rule 5101:3-3-43.2 of the Administrative Code.

(17) "Reporting period end date" (RPED) is the last day of each calendar quarter.

(18) "Reporting quarter" is the calendar quarter in which the MDS 2.0 is completed, as indicated by the assessment reference date in MDS 2.0 section A, item 3a, except as specified in paragraphs (C)(7) and (C)(9) of this rule.
(19) "Resident Assessment Instrument (RAI)" is the instrument used by NFs in Ohio to comply with 42 code of federal regulations (CFR) section 483.20 (10-1-04 edition http://www.gpoaccess.gov/cfr/index.html) and provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and identifies medical problems. The Ohio specified and federally approved instrument is composed of the MDS 2.0, triggers, RAPs and the RAP summary form.

(20) "Resident case mix score" is the relative resource weight for the RUG III group to which the resident is assigned based on data elements from the resident's MDS 2.0 assessment.

(21) "Resident identifier code" is an alternative resident identifier if the resident does not have a social security number. The resident identifier code shall be reported in MDS 2.0 item S12. Refer to instructions in the section S state of Ohio supplement located at http://www.odh.ohio.gov/odhprograms/io/mds/mds_btins.aspx

(22) "RUG III" is the resource utilization groups, version III system of classifying NF residents into case mix groups described in paragraph (B) of rule 5101:3-3-43.2 of the Administrative Code. Resource utilization groups are clusters of NF residents, defined by resident characteristics, that correlate with resource use.

(23) "Semiannual facility average medicaid case mix score" is the average of a facility's two quarterly facility average medicaid case mix scores. It is used to establish the direct care rate and calculated pursuant to paragraph (E) of rule 5101:3-3-43.3 of the Administrative Code.

(B) For the purpose of determining medicaid payment rates for NFs effective October 1, 2000 and thereafter, ODJFS shall accept the RAI specified by the state and approved by CMS. Each NF shall assess all residents of medicaid-certified beds as defined in this rule, using the MDS 2.0 as set forth in appendix A or appendix E of this rule. When the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) assessment and medicare assessment time frames coincide, one assessment shall be used to satisfy both assessments. Admission assessments must be combined with either the medicare five day or medicare fourteen day assessment. For a resident who is not a new admission to the facility, the quarterly, the annual, and significant change in status assessments must be combined with any medicare assessment if the assessment reference date (ARD) is within the assigned medicare observation period. When combining the OBRA and medicare assessments, the most stringent requirement for MDS completion must be met.
(1) Comprehensive assessments, medicare-required assessments, quarterly review assessments and significant corrections of quarterly assessments must be conducted in accordance with the requirements and frequency schedule found at 42 CFR section 483.20 (10-1-04 edition http://www.gpoaccess.gov/cfr/index.html).

(2) NFs must use the Ohio specified MDS 2.0, as set forth in appendix A of this rule, including sections S, T, and W for all comprehensive assessments, significant change assessments, and significant correction assessments. NFs may use the Ohio specified MDS 2.0 as set forth in appendix A of this rule including sections S, T, and W for the quarterly review assessment.

(3) NFs must use the MDS 2.0 discharge tracking form as set forth in appendix B of this rule for any residents who transfer, are discharged or expire, and the MDS 2.0 reentry tracking form as set forth in appendix C of this rule for any residents reentering the facility in accordance with 42 CFR section 483.20.

(4) NFs must use the MDS correction request form as set forth in appendix D of this rule for modification or inactivation of MDS records that have been accepted into the state MDS database.

(5) NFs may use the MDS medicare PPS (prospective payment system) assessment form (MPAF) (http://www.odh.ohio.gov/odhprograms/io/mds/mds_vendor.aspx) as set forth in appendix E of this rule for all medicare required assessments. When the assessment reference date (ARD) is subsequent to the RPED, the date of entry (MDS 2.0 item AB1) must also be submitted for medicaid rate setting purposes as delineated in the "CMS Revised Long-Term Care Resident Assessment Instrument User's Manual version 2.0" (December 2002, http://www.cms.hhs.gov/nursinghomequalityinitis/20_nhqimds20.asp). NFs may use the MPAF as set forth in appendix E of this rule for quarterly review assessments.

(C) Effective July 1, 1998, all NFs must submit to the state encoded, accurate, and complete MDS 2.0 data for all residents of medicaid certified NF beds, regardless of pay source or anticipated length of stay.

(1) MDS 2.0 data completed in accordance with paragraphs (B)(1) to (B)(5) of this rule must be encoded in accordance with 42 CFR section 483.20, CMS' uniform data submission document, and state record layout specifications.

(2) MDS 2.0 data must be submitted in an electronic format and in accordance with
the frequency schedule found in 42 CFR section 483.20. The data may be submitted at any time during the reporting quarter that is permitted by instructions issued by the state, except as provided in paragraphs (D) and (E) of this rule, all records used in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score must be submitted by the filing date.

(3) If a NF submits MDS 2.0 data needed for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score after the eightieth day after the RPED, ODJFS may assign a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(4) MDS 2.0 data submitted by a provider that can not be timely extracted by ODJFS from the CMS data server may result in assignment of a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(5) The annual, semiannual, and quarterly facility average total case mix score and quarterly facility average medicaid case mix score will be calculated using the MDS 2.0 record in effect on the RPED for:

(a) Residents who were admitted to the medicaid certified NF prior to the RPED and continue to be physically present in the NF on the RPED; and

(b) Residents who were admitted to the medicaid certified NF on the RPED; and

(c) Residents who were temporarily absent on the RPED but are considered residents and for whom a return is anticipated from hospital stays, visits with friends or relatives, or participation in therapeutic programs outside the facility.

(6) Records for residents who were permanently discharged from the NF, transferred to another NF, or expired prior to or on the RPED will not be used for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score.
(7) For a resident admitted within fourteen days prior to the RPED, and whose initial assessment is not due until after the RPED, both of the following shall apply:

(a) The NF shall submit the appropriate initial assessment as specified in the MDS 2.0 manual (December 2005 http://www.cms.hhs.gov/nursinghomequalityinitis/20_nhqmads20.asp) and in 42 CFR 483.20.

(b) The initial assessment, if completed and submitted timely in accordance with paragraphs (C)(1) and (C)(2) of this rule, shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score in the quarter the resident entered the facility even if the assessment reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code.

(8) For a resident discharged prior to the completion of an initial assessment, all of the following shall apply:

(a) The NF shall submit a discharge tracking form with the reason for assessment (MDS 2.0, item AA8a) coded as "08" (zero eight), discharged prior to completing initial assessment.

(b) The discharge status (MDS 2.0 item R3) shall be coded "1" through "9" as appropriate.

(c) The resident specific case mix score for clinically complex category, group twenty-two, class "CC1" shall be assigned for a resident of the facility on the RPED who was either:

  (i) Admitted in the final fourteen days of the calendar quarter and whose initial assessment was not completed because the resident was discharged or expired.

  (ii) Admitted in the final thirty days of the calendar quarter and was admitted to the hospital prior to the completion of the initial assessment, and is still in the hospital on the RPED.

(9) For a resident who had at least one MDS 2.0 assessment completed before being
transferred to a hospital, who then reenters the NF within fourteen days prior to the RPED, and has experienced a significant change in status that requires a comprehensive assessment upon reentry, the following shall apply:

(a) The NF shall submit a significant change assessment within fourteen days of reentry, as indicated by the MDS 2.0 assessment reference date (MDS 2.0, item A3).

(b) The significant change assessment shall be used for determining the quarterly facility average total case mix score and **may be used for determining the** quarterly facility average medicaid case mix score for the quarter in which the resident reentered the facility even if the assessment reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code.

(D) Corrections to MDS 2.0 data must be made in accordance with the requirements in the "CMS Revised Long Term Care Resident Assessment Instrument User's Manual version 2.0", and the "State Operations Manual" issued by CMS (http://new.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage) and,

(1) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, the facility must transmit the corrections to the state no later than eighty days after the RPED.

(2) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, all significant correction assessments must contain an assessment reference date within the reporting quarter.

(3) The provider shall submit an accurate, encoded MDS 2.0 record for each resident in a medicaid certified bed on the RPED.

(a) The provider shall transmit MDS 2.0 assessments that were completed timely but omitted from the previous transmissions and ODJFS shall use the resident case mix scores from the assessments for determining the quarterly facility average total case mix score and **may be used for determining the** quarterly facility average medicaid case mix score, if the assessments are transmitted no later than eighty days after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code. If the assessments are not transmitted within eighty days after the RPED, ODJFS may assign a default group for
those records.

(b) The provider shall notify ODJFS within eighty days of the RPED of any records for residents in medicaid certified beds on the RPED that were not completed timely and were not transmitted to the state. ODJFS may assign default scores to those records as described in paragraph (F) of rule 5101:3-3-43.2 of the Administrative Code.

c) The provider has eighty days after the RPED to transmit the appropriate discharge tracking form to the state, if more residents are determined as being in the facility on the RPED than the number of its medicaid certified beds. If the facility does not correct the error within eighty days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

d) The provider shall notify ODJFS within eighty days of the RPED of any residents who were reported to be residents of the facility on the RPED, but who had actually been discharged prior to the RPED. If the provider fails to correct the error within eighty days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

e) The provider has eighty days after the RPED to submit appropriate modifications or discharge tracking records to rectify any discrepancy between the records selected for determining the quarterly facility average total case mix score and the facility census on the RPED. If the facility does not correct the error(s) within eighty days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(4) If the provider's number of records assigned to the default group in accordance with paragraphs (D)(3)(a) and (D)(3)(b) of this rule is greater than ten percent, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.
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