Welcome to
MDS 3.0 Training 2026
Session #6

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This presentation is not a substitute for reading and reviewing the

Long-Term Care Resident Assessment Instrument 3.0 User's Manual
Version 1.20. 1, October 2025
Item Sets Version 1.20.3 October 2025

or

State Operations Manual Appendix PP
Revised 7/23/25

Objectives

Participants will:

Review the Use of Section X

Understand the Importance of Section Z

Recognize the Importance of Timely Transmissions

Helpful Resources

Section X:
Correction Request

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the Internet Quality Improvement and Evaluation System (iQIES) system.

Corrections/modifications should be made within 14 days of discovery and submitted within 14 days of the attestation date.

Section X (continued)
Major vs Minor Errors

Check your validation reports.

Significant Error is an error in an assessment where:

- 1. the resident's overall clinical status is not accurately represented and
- 2. the error has not been corrected via submission of a more recent assessment.

RAI page 2-23 through 2-33

Minor errors are all other errors related to coding the MDS.

Section X: A0050 Modifications (continued)

Create a corrected MDS record with all item included, not just the items in error.

Complete Section X (correction request) to identify the record that needs to be modified and include with the corrected record.

Submit both the Section X and the corrected record to iQIES.

A hard copy of the Section X must be kept with corrected paper copies of the MDS record in the clinical file to track changes. A hard copy of Section X should also be kept with any inactivated record.

Inactivation vs Modification

Modification can be used for most items

Entry and discharge dates, ARD when it was a typographical error and when type of assessment does not change the item set.

Inactivation needs to be followed by a new record with a new ARD.

Correction/Deletion request is required to correct: Unit Certification or Licensure Designation (A0410).

Accidental transmission of a resident who never entered the facility.

The facility must submit a request to the state MDS Coordinator to have these problems fixed. See chapter 5 pages 13-14 for more information.

Section X: Correcting Significant Errors(continued)

When any significant error is discovered in an OBRA comprehensive or quarterly assessment in the iQIES system, the nursing home must take the following actions to correct the OBRA assessment:

Create a corrected record with all items included, not just the items in error.

Complete the required correction request section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.

Submit this modification request record.

Perform a new Significant Correction to Prior Assessment (SCPA) or Significant Change in Status Assessment (SCSA) and update the care plan as necessary.

Section Z: Assessment Administration

The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

Rational: Used to capture the Patient Driven Payment Model (PDPM) case mix version code followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

HIPPS Codes

DEFINITION HIPPS CODE:

Health Insurance Prospective Payment System code is comprised of the PDPM case mix code, which is calculated from the assessment data. The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement, followed by an indicator of the type of assessment that was completed.

HIPPS Codes continued

1st Character: PT/OT Payment Group

2nd Character: SLP Payment Group

3rd Character: Nursing Payment Group

4th Character: NTA Payment Group

5th Character: PPS Assessment Indictor Code

See RAI Chapter 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

Section Z: Assessment Administration

Z0400: Signatures of all persons who completed any part of the MDS.

- Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement.
- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

Assessment Administration continued

Z0500: Signature of the RN Assessment Coordinator

- Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete. F641
- The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Signature Date

Signature Date:

- Gathering information from staff, family or significant others about the resident's status should be done after the observation period ends so as to capture information from the entire look back period.
- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
- If a staff member cannot sign Z0400 on the same day that they completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.

Transmitting MDS Data

From RAI page 5-1:

Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans.

Validation Reports

Please review your transmission validation reports regularly.

- Reviewing will help you identify and correct errors
- Reviewing will help prevent “missing assessments” and duplicate folders in the CMS data base
- Reviewing will help ensure the facility will be paid

From RAI page 5-2

-When the transmission file is received by iQIES, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards.

-MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by iQIES for the same resident.

-The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report.

-All error and warning messages are detailed and explained in the Error Messages guide.

Validation Report References

iQIES Resources are available at:
https://qtso.cms.gov/software/iqies/reference-manuals

CASPER Reporting User's Guide For MDS Providers is available at:
https://qtso.cms.gov/reference-and-manuals/casper-reporting-users-guide-mds-providers

REVIEW of the PRELIMINARY RESIDENT ROSTER REPORT

The Preliminary Resident Roster is provided as a tool for use by the facility in determining whether any missing or incorrect assessments/records are noted

Allows for review, corrections, modifications, inactivation, transmissions of assessments on or before the cutoff date of the Final Resident Roster CMI report…

https://myersandstauffer.com/client-portal/north-carolina/

The Slippery Slope of Uncorrected MDS Assessments

Assessments are not reviewed for accuracy prior to transmittal

MDS 3.0 Final Validation Reports are not reviewed *or* if they are reviewed warning and error messages are not acted upon

MDS 3.0 Missing OBRA Assessment Report which is available in iQIES is not reviewed

MDS 3.0 Activity Report which is available in iQIES is not reviewed

Now the problem shows up on the Myers & Stauffer Preliminary Time-Weighted CMI Resident Roster Report for your correction

Your RAI Coordinator receives from Myers & Stauffer the Potential Duplicate Resident Report to assist facilities in making corrections

"MISSING" ASSESSMENTS DO NOT NEED TO GET THIS FAR!

WHY NOT BE PROACTIVE?

Having edits in place to check for accuracy before transmission will help prevent inaccuracies of the identification information

Hold the person responsible for reviewing the validation reports accountable

Checking the MDS 3.0 Missing OBRA Assessment Report and MDS 3.0 Activity Report regularly only takes a few moments and is time well spent

Section A:
Identification Information

Remember:

The CMS Database

matching process includes:

- First Name
- Last Name
- Social Security Number
- Sex
- Date of Birth

Please communicate regarding any changes to the resident's demographic information

Code of Federal Regulations (CFR)

State Operations Manual Appendix PP revised 7/23/25:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

F640
Encoding/Transmitting Resident Assessment

INTENT

To ensure that facilities have provided resident specific information for payment and quality measure purposes.

To enable a facility to better monitor each resident's decline and progress over time.

F640 Definitions, in part

"Accurate" means that the encoded MDS data matches the MDS form in the clinical record. Also refer to guidance regarding accuracy at F641, and the information accurately reflects the resident's status as of the Assessment Reference Date (ARD).

"Capable of transmitting" means that the facility has encoded and edited according to CMS specifications, the record accurately reflects the resident's overall clinical status as of the assessment reference date, and the record is ready for transmission.

"Complete" means that all items required according to the record type, and in accordance with CMS' record specifications and State required edits are in effect at the time the record is completed.

"Discharge subset of items" refers to the MDS Discharge assessment.

"Encoding" means entering information into the facility MDS software in the computer.

"Transmitted" means electronically transmitting to iQIES, an MDS record that passes CMS' standard edits and is accepted into the system, within 14 days of the final completion date, or event date in the case of Entry and Death in Facility situations, of the record.

F640 Guidance

Facilities are required to electronically transmit MDS data to the CMS System for each resident in the facility.

For the subset of items required upon a resident's entry, transfer, discharge and death refer to Chapter 2 of the Long-Term Care Resident Assessment Instrument User's Manual for further information about these records.

- For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).

Submission must be according to State and Federal time frames. Electronically submit MDS information to the iQIES system within 14 days:

Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).

Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

F641
Coordination/Certification of Assessment

Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

Certification. A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Penalty for Falsification.

F641 Guidance

Patterns of MDS Assessment and Submissions

MDS information serves as the

- clinical basis for care planning and care delivery and
- provides information for Medicare and Medicaid payment systems,
- quality monitoring and public reporting.

MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process.

A willfully and knowingly-provided false assessment may be indicative of payment fraud or attempts to avoid reporting negative quality measures.

F641 Guidance (continued)

All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).

A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher Resource Utilization Group (RUG) scores, un-triggering Care Area Assessments (CAAs) or unflagging Quality Measures (QMs), where the information does not accurately reflect the resident's status, may be indicative of payment fraud or attempts to avoid reporting negative quality measures….

CMS.gov
Choose “Spotlights and Announcements” for newest information for SNFs

MDS RAI Manual Version 1.20.1 effective October 2025

MDS RAI Manual version 1.20.1 and
MDS 3.0 v1.20.4 item set available:

https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

Final Rule: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/administrative-information-memos-states-and-regions/fiscal-year-fy-2025-mission-priorities-document-mpd-action

Find the MDS 3.0 Item Details

SNF QRP Information webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation

MDS 3.0 Technical Information, Data Submission Specifications: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation

Additional information about CMS specification of the RAI and variations in format can be found in Sections 4145.1–4145.7 of the CMS State Operations Manual (SOM) which can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

https://www.cms.gov/medicare/quality/nursing-home-improvement/quality-measures

MDS 3.0 Quality Measures USER'S MANUAL (v18.0)

Effective January 1, 2026

https://www.cms.gov/medicare/quality/nursing-home-improvement/quality-measures

Helpful Resource for Documentation

Medicare Benefit Policy Chapter 8 Coverage of SNF Services:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

NC Medicaid, Nursing Facility Services Clinical Coverage Policy:

https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies

https://medicaid.ncdhhs.gov/2b-1-nursing-facilities/download?attachment

Myers and Stauffer:
https://myersandstauffer.com/client-portal/north-carolina/

Other helpful sites

CMS Nursing Home Resource Center

https://www.cms.gov/nursing-homes

CMS You-tube training videos June 2023

https://www.youtube.com/playlist?list=PLaV7m2-zFKphoXW6cc3NwUfxra0A1LYDi

Survey Resources

https://www.cms.gov/medicare/Provider-enrollment-and-certification/guidanceforLawsandRegulations/Nursing-Homes

https://www.cms.gov/medicare/quality/snf-quality-reporting-program/training
Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Training
Achieving a Full APU Webinar Training

Section C and D Training Materials: Cognitive & Mood Assessment
Section D Training Materials: Resident Mood Interview (PHQ-9©) Video Tutorial
Section GG Training Materials: Section GG 3-Course Training Series
Section J Training Materials: Health Conditions: Coding the Standardized Patient Assessment Data Elements Related to Falls
Section K Training Materials: Swallowing/Nutritional Status: Height, Weight, and Nutritional Approaches
Section M Training Materials: Assessment and Coding of Pressure Ulcers/Injuries
Section N Training Materials: Medications – Drug Regimen Review
Section O Training Materials: Section O: O0100. Special Procedures, Treatments, and Programs
Job Aids – GG0130A. Eating, GG0130B. Oral Hygiene, GG0130C. Toileting Hygiene, GG0130E. Shower/Bathe Self, GG0130F. Upper Body Dressing, GG0130G. Lower Body Dressing, and GG0130H. Putting On/Taking Off Footwear
Pocket Guides / Badge Buddies, SNF QRP Tip Sheets

RAI pages 2-17 through 2-20

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