F641

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§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.

§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

§483.20(i) Certification.

§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.

§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

§483.20(j) Penalty for Falsification.

§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly—

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.

INTENT

To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.

GUIDANCE

"Accuracy of Assessment" means that the appropriate, health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the

appropriate Resident Assessment Instrument (RAI) (*e.g.* comprehensive, quarterly, significant change in status).

Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

The determination of appropriate participation of health professionals must be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs.

The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the Look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.

When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

The initial comprehensive assessment provides starting point data for ongoing assessment of resident progress.

Inaccurate MDS Diagnosis Coding

CMS is aware of situations where residents are given a diagnois of schizophrenia without sufficient supporting documentation that meets the criteria in the current version of the DSM for diagnosing schizophrenia. For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.

Surveyors should investigate this concern through record review and interviews with staff who completed the assessment. Surveyors are not questioning the physician's medical judgement, but rather, they are evaluating whether the medical record contains supporting documentation for the diagnosis to verify the accuracy of the resident assessment.

If the facility is unable to provide documentation which supports the MDS coding of the new diagnosis in question, then noncompliance exists at §483.20(g) and (i)(2). Supporting documentation should include, but is not limited to, evaluation(s) of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASARR) evaluation.

One or two assessments with inaccurate MDS diagnosis coding should be cited as isolated. If the surveyor identifies a pattern (i.e., three or more) of inaccurate coding for any new diagnosis (such as schizophrenia) with no supporting documentation by a physician, the surveyor should cite the scope of the non-compliance at a minimum of pattern or widespread as appropriate, make a referral to the State Board of Nursing, and see the guidance below in Investigative Procedures for making a referral to the Office of the Inspector General.

When concerns related to a diagnosis that lacks sufficient supporting documentation are identified, surveyors should review:

- *F658: to determine if the documentation supports a diagnosis in accordance with standards of practice.*
- *F644: to determine if the facility made a referral to the state designated authority when a newly evident or possible serious mental disorder was identified.*
- *F605: to evaluate psychotropic medication use based on a comprehensive assessment.*
- *F841: to evaluate the medical director's oversight of medical care.*

Certification of Accuracy and Completion

Whether Minimum Data Set (MDS) assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the assessment.

Electronic Signatures

When MDS forms are completed directly on the facility's computer (i.e., no paper form has been manually completed), then each individual assessor signs and dates a computer-generated hard copy, or provides an electronic signature, after they review it for accuracy of the portion(s) they completed.

Facilities may use electronic signatures on the MDS when permitted to do so by state and local law and when this is authorized by the facility's policy. Additionally, the facility must have written policies in place to ensure proper security measures are in place to protect use of an electronic signature by anyone other than the person to which the electronic signature belongs. The policy must also ensure access to a hard copy of clinical records is made available to surveyors and others who are authorized access to clinical records by law, including the resident and/or resident representative.

Facilities that are not capable of maintaining the MDS signatures electronically must adhere to the current federal requirements at §483.20(d) addressing the need for either a hand-written

copy or a computer-generated form. All state licensure and state practice regulations continue to apply to certified facilities.

***NOTE:** Where state law or regulations are more restrictive than federal requirements, the provider needs to apply the state law standard.*

***Backdating Completion Dates -** Backdating completion dates is not acceptable – note that recording the actual date of completion is not considered backdating. For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.*

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.

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 Patient Driven Payment Model (PDPM) scores, untriggering 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. Such practices may include, but are not limited to, a pattern or high prevalence of the following:

- *Submitting MDS Assessments (including any reason(s) for assessment, routine or non-routine) or tracking records, where the information does not accurately reflect the resident's status as of ARD, or the Discharge or Entry date, as applicable;*

- *Submitting correction(s) to information in the internet Quality Improvement Evaluation System (iQIES) where the corrected information does not accurately reflect the resident's status as of the original ARD, or the original Discharge or Entry date, as applicable, or where the record it claims to correct does not appear to have been in error;*

- *Submitting Significant Correction Assessments where the assessment it claims to correct does not appear to have been in error;*

- *Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met;*

- *Delaying or withholding MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Entry Tracking information, or correction(s) to information in the iQIES system.*

INVESTIGATIVE PROCEDURES

Use the Resident Assessment Critical Element Pathway a) when MDS concerns are noted but you are not using a care area pathway (i.e., the care area did not require further investigation), or b) for concerns about the facility's MDS data completion or submission activities, along with the above guidance, when determining if the facility meets the requirements for, or investigating concerns related to resident assessment.

Surveyors are expected to focus on MDS coding accuracy but are not expected to investigate possible falsification of the resident assessment instrument.

If the surveyor identifies a pattern (i.e., three or more residents) of inaccurate MDS coding by staff who completed, signed, and certified to the accuracy of the portion of the assessment they completed, and there are indications or concerns that the individual who completed the section(s) in question knew the coding was inaccurate, a referral should be made to the Office of Inspector General for investigation of falsification per §483.20(j). See the Submit a Hotline Complaint section, under the Fraud tab, on the Department of Health & Human Services Office of the Inspector General's Office webpage at https://oig.hhs.gov/fraud/report-fraud/index.asp.

PROBES

- Based on your total review of the resident, observations, interviews and record reviews, does each portion of the MDS assessment accurately reflect the resident's status as of the Assessment Reference Date?

- Is there evidence that the health professionals who assessed the resident had the skills and qualifications to conduct the assessment? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident?

- *Are the appropriate certifications in place, including the RN Coordinator's certification of completion of an MDS assessment or Correction Request, and the certification of individual assessors of the accuracy and completion of the portion(s) of the assessment or tracking record completed?*