The effective date is March 23, 1998 (except for the facility computerization requirements which take effect June 22, 1998.)

FEDERAL REGISTER, December 23, 1997

REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES
Sec. 483.20 Resident assessment in long term care facilities.

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Medicare/Medicaid: Resident Assessment In Long Term Care Facilities- HCFA’s New Rule.

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ment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident’s transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting data. Within 7 days after a facility completes a resident’s assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State.

(3) Monthly transmittal requirements. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following:

(i) Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident’s transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data format. The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA.

(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

(g) Accuracy of assessments. The assessment must accurately reflect the resident’s status.

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

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

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

(j) Penalty for falsification. (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 of not more than $5,000 for each assessment.

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

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Subpart F--Requirements That Must be Met by States and State Agencies, Resident Assessment

Sec. 483.315 Specification of resident assessment instrument.

(b) ...The RAI that the State specifies must be one of the following:

(1) The instrument designated by HCFA.
(2) An alternate instrument specified by the State and approved by HCFA.
(3) After specifying an instrument, the State must provide periodic educational programs for facility staff to assist with implementation of the RAI.

(e) Minimum data set (MDS). The MDS includes assessment in the following areas:

(1) Identification and demographic information, which includes information to identify the resident and facility, the resident’s residential history, education, the reason for the assessment, guardianship status and information regarding advance directives, and information regarding mental health history.

(2) Customary routine, which includes the resident’s lifestyle prior to admission to the facility.

(3) Cognitive patterns, which include memory, decision making, consciousness, behavioral measures of delirium, and stability of condition.

(4) Communication, which includes scales for measuring hearing and communication skills, information on how the resident expresses himself or herself, and stability of communicative ability.

(5) Vision pattern, which includes a scale for measuring vision and vision problems.

(6) Mood and behavior patterns, which include scales for measuring behavioral indicators and symptoms, and stability of condition.

(7) Psychosocial well-being, which includes the resident’s interpersonal relationships and adjustment factors.

(8) Physical functioning and structural problems, which contains scales for measuring activities of daily living, mobility, potential for improvement, and stability of functioning.

(9) Continence, which includes assessment scales for bowel and bladder incontinence, continence patterns, interventions, and stability of continence status.

(10) Disease diagnoses and health conditions, which includes active medical diagnoses, physical problems, pain assessment, and stability of condition.

(11) Dental and nutritional status, which includes information on height and weight, nutritional problems and accommodations, oral care and problems, and measure of nutritional intake.

(12) Skin condition, which includes current and historical assessment of skin problems, treatments, and information regarding foot care.

(13) Activity pursuit, which gathers in-

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formation on the resident's activity preferences and the amount of time spent participating in activities.

(14) Medications, which contains information on the types and numbers of medications the resident receives.

(15) Special treatments and procedures, which includes measurements of therapies, assessment of rehabilitation/restorative care, special programs and interventions, and information on hospital visits and physician involvement.

(16) Discharge potential, which assesses the possibility of discharging the resident and discharge status.

(17) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.

(18) Documentation of participation in assessment.

(f) Resident assessment protocols (RAPs). At a minimum, the RAPs address the following domains:

(1) Delirium.
(2) Cognitive loss.
(3) Visual function.
(4) Communication.
(5) ADL functional/rehabilitation potential.
(6) Urinary incontinence and indwelling catheter.
(7) Psychosocial well-being.
(8) Mood state.
(9) Behavioral symptoms.
(10) Activities.
(11) Falls.
(12) Nutritional status.
(13) Feeding tubes.
(14) Dehydration/fluid maintenance.
(15) Dental care.
(16) Pressure ulcers.
(17) Psychotropic drug use.
(18) Physical restraints.

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