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## Owners/Administrators Guide to Preliminary CMI Listings

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Many case mix states mail out or distribute through the CMS servers preliminary CMI listings. These are not used for rate setting, but they give the nursing facility another opportunity to review its MDS transmissions and in some cases the payer source designations before the final CMI listing used for rate setting. In many states, there is only a two-week window between the time these reports become available to facilities and the “cutoff” date, meaning the last date by which MDS transmission for the final CMI listing may be accepted. So for everybody in your building dealing with the rate-setting process besides the accountant, the preliminary report, when it becomes available, should become a top priority.

This guide is meant to be generic, so not every word here will apply to each state. Feel free to contact the author with specific questions in your state.

Most facilities have at least two employees who should be involved. Titles vary, so for the purposes of this guide, four roles will be defined:

1. **MDS Transmitter:** This is the employee who enters the assessments into the MDS software system at the facility, submits the transmission file through the AT&T Global Network and (hopefully!) reads the CMS Final Validation Report to be sure the correct assessments and tracking forms were accepted. Sometimes this function is carried out by a management company or corporate headquarters.
2. **RAI Coordinator:** This is the employee who oversees the collection of data and completion of the assessment. Often called the MDS Coordinator. This role is often combined with that of MDS Transmitter.
3. **Biller:** This person informs the MDS staff of the payer status of the resident so that the staff knows if it needs to schedule Medicare assessments. In some states, the facility can modify the payer status of the resident on the preliminary report and mail in the correction to the state or its contractor. The biller would typically know the payer source of the resident as of the point-in-time date.
4. **Consultant:** This person is charged with improving the accuracy of the assessments, the supportive documentation, improving reimbursement, filling-in when MDS coordinators are absent, etc. They can be employees of the corporation or independent.

I'd divide the review of the preliminary report into the following steps. I've identified the typical employees in the facility who perform these operations and the degree of difficulty:

1. Ensure that residents who belong on the listing are there and residents who don't belong aren't there. *Duty: MDS Transmitter. Difficulty: Basic.*
2. Ensure that each resident who appears on the listing has the correct assessment on the report. *Duty: MDS Transmitter. Difficulty: Basic.*
3. Ensure that each resident who appears on the listing has the correct payer source. *Duty: Biller. Difficulty: Basic.*

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4. Determine the accuracy of the RUG-III Categories appearing on the listing and take appropriate measures if they are inaccurate. *Duty: RAI Coordinator or Consultant. Difficulty: Advanced.*

Task 1: Ensure that residents who belong on the listing are there and residents who don't belong aren't there. *Duty: MDS Transmitter. Difficulty: Basic.*

CMI Listings are of two-types: point-in-time (“snapshot dates”) or time-weighted.

For point-in-time dates, generate a facility census with your facility's software for who was in the building as of the point-in-time date. If you can, sort this by resident last name then resident first name. With some exceptions, this list should be the same as your preliminary CMI listing.<sup>1</sup>

If a resident does not appear on the listing, it is probably because the resident discharged and reentered but the facility neglected to submit successfully the reentry tracking form or because the facility neglected to submit successfully the resident's first assessment.

Alternatively, if a resident appears on the listing who should not be on the listing, then the discharge tracking form was not accepted by the state.

Another scenario is that the tracking forms were accepted, but incorrect resident identification information or incorrect discharge or reentry dates resulted in the incorrect preliminary CMI listing.

For these reasons, it is critical to review the CMS Final Validation report (some states also have their own validation reports) and investigate warning messages.<sup>2</sup>

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<sup>1</sup> Some states count residents who were discharged return anticipated (AA8a = “07”) prior to the point-in-time date for rate-setting purposes. Some states do not count residents who were in the building as of the point-in-time date but whose initial assessments were not completed until after the point-in-time date.

<sup>2</sup> A by no-means comprehensive list of warning messages on the CMS Final Validation Reports which may indicate problems in your CMI listings includes the following from the QIES Technical Support Office (<http://www.qtso.com>):

- 70: Assessment completed late: The submitted R2b date was > 92 days after the R2b date submitted previously.
- 71: Inconsistent record sequence: The submitted reason for assessment (AA8a/AA8b) does not logically follow the reason for assessment (AA8a/AA8b) previously submitted.
- 72: Inconsistent submission sequence: Records appear to have been submitted out of order. The dates in the submitted record do not sequentially follow the dates of the previous record.

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In no cases should one resident appear two or more times on a point-in-time listing.

Time weighted reports have a begin date and an end date, typically three calendar months such as January 1-March 31. They typically include at least two records for each resident, an assessment prior to the period of the report and an assessment approximately 92 days later during the time period or a discharge. Medicare payer source residents will usually have more records, and some residents will have significant change assessments and discharges and reentries.

For time-weighted reports, print a roster using your facility's software for the first and last days of the reporting period (in the above example, January 1 and March 31). Make sure that everybody who was in the facility on the first date appears in the time-weighted report and that everybody who appears in the time-weighted report has a discharge as the last record in the time-weighted report if they were not on the final date's roster in the facility.

The time weighted report shows the number of days an assessment is counted for rate-setting purposes. Any number exceeding 92 is a flag that either an assessment was not completed on time or an assessment or tracking form was not properly submitted to the CMS server.<sup>3</sup>

Task 2: Ensure that each resident who appears on the listing has the correct assessment on the report. *Duty: MDS Transmitter. Difficulty: Basic.*

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-216: R2b date late: The submitted assessment completion date (R2b) was more than 14 days later than the date of entry (AB1), or reentry date (A4a) whichever is later. *Author's note: This is specific to the admission assessment.*

-226: R2b date late: The submitted assessment completion date (R2b) was more than 14 days later than the assessment reference date (A3a).

-379: New resident: new person has been created the database the CMS MDS system at the State with the information submitted in this record. *Author's note: You should only see this message on the first record you transmit for a resident, which should be an Admission Assessment (AA8a="01"), a Medicare 5-day (AA8b = "1") or a Discharge Prior to Completion of Initial Assessment (AA8a = "07").*

-397: Inconsistent AA8a/R4/AB1: If AA8a = 08, then the R4 date must be less than or equal to 14 days after AB1 date.

<sup>3</sup> Medicare assessments will typically not exceed 40 days. The last Medicare assessment may also be an OBRA assessment (admission, quarterly or significant change), in which case, if the resident does not discharge, it may run up to 92 days.

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For point-in-time CMI listings, the last assessment which should appear on the report is the latest assessment completed prior to the point-in-time date.<sup>4</sup> If this assessment does not appear, it was not submitted correctly.

If these two steps are done properly, a facility should **never** receive a delinquent assessment in its CMI report, unless in fact the facility failed to do an OBRA required assessment. If a delinquent assessment appears in a preliminary CMI listing, the corporation or owner or administrator should ask the MDS transmitter to take appropriate action and then verify with the state RAI coordinator<sup>5</sup> that all records for a resident have been accepted with **one internal resident ID**<sup>6</sup> and with **correct dates**.<sup>7</sup>

Task 3: Ensure that each resident who appears on the listing has the correct payer source.  
*Duty: Biller. Difficulty: Basic.*

Most case mix states calculate a CMI average for the Medicaid payer source and a CMI average for all residents in the facility. Many then lower the per diem reimbursement to the extent that the facility CMI is higher than the facility Medicaid CMI. Also, many states have special payment arrangements for certain categories of residents. For these reasons, it is important to correct any incorrect payer sources on the preliminary listing.<sup>8</sup>

Task 4: Determine the accuracy of the RUG-III Categories appearing on the listing and take appropriate measures if they are inaccurate. *Duty: RAI Coordinator or Consultant. Difficulty: Advanced.*

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<sup>4</sup> Some states define "completion" as the Assessment Reference Date ("ARD", A3a on the MDS). Some states use the RN Signature Date (R2b on the MDS). Some states will "look forward" if the last record before the point-in-time was a reentry and there is an assessment within fourteen (14) days of the reentry.

<sup>5</sup> The state RAI coordinator is usually the only person who has access to the most current data. Contractors who produce many of the states' preliminary CMI listings will only have access to the data as of the "cutoff date" for the preliminary CMI listing.

<sup>6</sup> The internal resident ID is the number used in the CMS database to identify a resident and is printed on the CMS Final Validation Report. One resident should have one internal resident ID only. If, through errors in resident identification information such as date of birth, gender, name and SSN, a second internal resident ID is created, the facility should contact the state RAI coordinator and ask what it needs to do to fix the data.

<sup>7</sup> The important dates are A3a, R2b, A4a (Reentry Date), R4 (Discharge Date) and AB1 (Date of Entry).

<sup>8</sup> Many states allow the facility to code "+" for Pending Medicaid in AA7 and will from that point forward consider the resident to have a Medicaid payer source. If a resident should be Medicaid, check the assessment's value at AA7 and make sure it was coded properly. Note that "P" and "Pending" are not valid values. Some states may require modification requests submitted to the state server. Other states may require a paper correction to be mailed in.

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Facilities should always focus on the accuracy of assessments. With the advent of acuity-based Medicare and Medicaid reimbursement, the facilities' financial health is also at stake.

The RAI coordinator or the consultant should have a mental picture of each resident and compare that with the RUG-III category which appears on the listing. If Jane Resident is totally ADL dependent yet appears on the listing with CA1 (ADL score 4-11 in the 5.12 grouper, i.e. relatively independent), then the assessment should be reviewed for coding errors and a modification request should be submitted if appropriate.

Of course, this is just the tip of the iceberg as far as MDS quality improvement is concerned. To see where your facility stands, simply select some assessments from your last CMI listing and review their documentation and a current assessment for those residents.

In all cases, the facility must comply with the RAI Manual and the instructions of its state RAI coordinator. Often, the state Medicaid agency will also have a help desk to support facilities, and this is another important resource for your facility to use.