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GLOSSARY

ACRONYMS

ASAP ..... Assessment Submission And Processing

CASPER ..... Certification And Survey Provider Enhanced Reporting
CCN ..... CMS Certification Number
CMS ..... Centers For Medicare & Medicaid Services

FACID ..... Facility Identifier
FAQ ..... Frequently Asked Questions

GB ..... Gigabyte

ID ..... Identification
IRF-PAI ..... Inpatient Rehabilitation Facility Patient Assessment Instrument
ISC ..... Item Subset Code

LTC ..... Long Term Care

MB ..... Megabyte
MDS ..... Minimum Data Set
MHZ ..... Megahertz

NACD ..... National Assessment Collection Database
NF ..... Nursing Facility
NH ..... Nursing Home

OASIS ..... Outcome and Assessment Information Set

PC ..... Personal Computer
PPS ..... Prospective Payment System

OBRA ..... Omnibus Budget Reconciliation Act of 1981
OMRA ..... Other Medicare Required Assessment

QI ..... Quality Indicator
QM ..... Quality Measure
QIES ..... Quality Improvement and Evaluation System
QTSO ..... QIES Technical Support Office

RAI ..... Resident Assessment Instrument
RAM ..... Random Access Memory
RUG ..... Resource Utilization Group

SB ..... Swing Bed
SNF ..... Skilled Nursing Facility
SSN ..... Social Security Number

TERMINOLOGY

Term	Definition / Description
Facility ID	The Facility ID is a unique number assigned to the provider.
Final Validation Report	The Final Validation Report provides feedback about the status of the records submitted to the MDS 3.0 national system.
ISC	The Item Subset Code (ISC) is a two or three-byte code that indicates the type of transaction that is being submitted. The ISC is derived by the values contained in the A0200, A0310A, A0310B, A0310C, A0310D, and A0310F items. The set of active items that make up each transaction is controlled by the ISC. The bytes of the ISC are defined as follows: Byte 1 indicates the type of provider: N = nursing home or S = swing bed Byte 2 indicates the OBRA reason for assessment or PPS Assessment reason Byte 3 identifies if the record is also a discharge record The following is a list of the Item Subset Codes defined to the MDS 3.0 System: NC – Nursing home comprehensive assessment NQ – Nursing home quarterly assessment NP – Nursing home PPS assessment NS – Nursing home OMRA start-of-therapy assessment NSD – Nursing home OMRA start-of-therapy + discharge assessment NO – Nursing home OMRA other assessment NOD – Nursing home OMRA other + discharge assessment ND – Nursing home discharge assessment NT – Nursing home tracking record (entry/death record) SP – Swing bed PPS assessment SS – Swing bed OMRA start-of-therapy assessment SSD – Swing bed OMRA start-of-therapy + discharge assessment SO – Swing bed OMRA other assessment SD – Swing bed OMRA other + discharge assessment ST – Swing bed tracking record (entry/death record) XX – Inactivation record (nursing home or swing bed)
MDS	Minimum Data Set - this is a standardized assessment or questionnaire completed for residents in long term care facilities and swing bed units. Submission of the MDS 2.0 instrument has been required since 1998 and submission of the MDS 3.0 data set will be required effective the implementation date selected by CMS.

Term	Definition / Description
Nursing Home (NH)	The nursing home reference is synonymous with the following facility types: Skilled Nursing Facility - A facility (which meets specific regulatory certification requirements) which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. Nursing Facility - A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
SUB_REQ	Submission Required Indicator - this is item A0410 for MDS 3.0. The submission required field is used to identify whether or not there is authority to collect the submitted record. If the resident is on a Medicare or Medicaid certified unit, CMS has federal authority to collect the record *if* the target date for the assessment occurs while the resident is on that certified unit. Refer to the MDS 3.0 RAI Manual for additional information about item A0410.
Target Date	The target date is used to define when the event occurred for the resident. It is used to ensure that the record order matches the order that the events occurred for the resident.