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Chapter	Section	Page(s) in version 1.18.11	Change
App. A	—	—	Updated language throughout to be gender neutral.
App. A	—	A-1–A-28	Page length changed due to revised content and formatting.
App. A	—	A-1	**Active Discharge Plan** An ***active*** discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge, and there is a target discharge date for the near future. If there is not an ***active*** discharge plan, residents should be asked if they want to talk to someone about community living and then referred to the Local Contact Agency (LCA) accordingly. Furthermore, referrals to the LCA are recommended as part of many residents' discharge plans. Such referrals are a helpful source of information for residents and facilities in informing the discharge planning process.
App. A	—	A-2	**Activities of Daily Living** **ADLs** Activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ~~mobility (e.g., ~~ambulation~~)~~, toileting, eating, transferring, and communicating. Select self-care and mobility items from Section GG are utilized to classify a resident into the PT, OT, and nursing components for PDPM.

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App. A	—	A-2	**ADL Aspects**	Components of ADL activities. These are listed next to each ADL in the item set. For example, the aspects of ~~G0110H~~GG0130A (Eating) are ~~eating, drinking, and intake of nourishment or hydration by other means, including tube feeding, total parenteral nutrition, and IV fluids for hydration~~using suitable utensils to bring food and/or liquid to the mouth and swallowing food and/or liquid once the meal is placed before the resident.
App. A	—	A-2	~~**ADL Self-Performance Items**~~	~~Measures what the resident actually did (not what her or she might be capable of doing) within each ADL category according to a performance-based scale.~~
App. A	—	A-2	~~**ADL Support Provided**~~	~~Measures the highest level of support provided by staff, even if that level of support only occurred once, according to a support-based scale.~~
App. A	—	A-2	~~**Internal** **Assessment ID**~~	A sequential numeric identifier assigned to each record submitted to iQIES~~ASAP~~.
			Moved revised entry to correct alphabetical position in Glossary list	
App. A	—	A-2	**Assessment Period**	~~The time period during which the assessment coordinator starts the assessment until it is signed as complete.~~See Observation Period.

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App. A	—	A-3	**Assessment Reference Date** **ARD** The specific end-point for the look-back periods in the MDS assessment process. ~~This look-back period is also called the observation or assessment period.~~
App. A	—	A-3	~~**Assessment Submission and Processing System** **ASAP** The CMS system that receives submissions of MDS 3.0 data files, validates records for accuracy and appropriateness, and stores validated records in the CMS database.~~
App. A	—	A-3	**Assisted Living** A noninstitutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
App. A	—	A-3	**Board and Care** A noninstitutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
App. A	—	A-4	**CMS Certification Number** **CCN** Replaces the term "Medicare~~/Medicaid~~ Provider Number" in survey and certification, and assessment-related activities. Moved entry to correct alphabetical position in Glossary list

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App. A	—	A-5	**Critical Access Hospital** **CAH**	A Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all of the criteria established by CMS for designation as a CAH. Additional information on CAHs is available at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/cahs.html.
App. A	—	A-6	**Designated Local Contact Agency** **LCA**	Each state has ~~designated a local~~ community contact agency~~y~~ies ~~responsible for contacting the~~that can provide individuals with information about community living options and available community-based supports and services. ~~This~~These local contact agency~~y~~ies may be a single entry point agency, an Aging/Disabled Resource Center, an Area Agency on Aging, a Center for Independent Living, or other state ~~contractor~~designated entities.
App. A	—	A-7	**Duplicate ~~Assessment~~ Record Error**	A fatal record error that results from a resubmission of a record previously accepted into the CMS MDS database. A duplicate record is identified as having the same target date, reason for assessment, resident, and facility. This is the only fatal record error that does not require correction and resubmission.

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Chapter	Section	Page(s) in version 1.18.11	Change		
App. A	—	A-7	**Electronic Health Record**	**EHR**	An electronic version of a resident's medical history that is maintained by the provider over time. Sometimes referred to as an electronic medical record (EMR).
App. A	—	A-7	**Electronic Medical Record**	**EMR**	See Electronic Health Record.
App. A	—	A-7	**Entry Date**		The initial date of admission/entry to the ~~nursing home~~facility, or the date on which the resident most recently re-entered the ~~nursing home~~facility after being discharged (whether or not the return was anticipated).
App. A	—	A-7	**Facility ID**	**FAC_ ID**	The facility identification number is assigned to each ~~nursing~~ facility ~~by the State agency~~. The FAC_ID must be placed in the individual MDS and tracking form records. This normally is completed as a function within the facility's MDS data entry software.

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App. A	—	A-8	**Final Validation Report** **FVR**	A report generated after the successful submission of MDS 3.0 assessment data. This report lists all of the residents for whom assessments have been submitted in a particular submission batch and displays all errors and/or warnings that occurred during the validation process. An FVR ~~with a submission type of "production"~~ is a facility's documentation for successful file submission. An individual record listed on the FVR marked as "accepted" is documentation for successful record submission.
App. A	—	A-9	~~**Grace Days**~~	~~Predetermined additional days that may be added to the assessment window for Medicare scheduled assessments without incurring financial penalty. These may be used in situations such as an absence/illness or reassignment of the registered nurse (RN) assessment coordinator, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments.~~
App. A	—	A-9	**Gradual Dose Reduction** **GDR** **~~(GDR)~~**	Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued.

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App. A	—	A-9	**Group Home**	A noninstitutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
App. A	—	A-9	**Health Information Exchange** **HIE**	An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. HIEs can function at the federal, state and local level.
App. A	—	A-10	**Health Insurance Prospective Payment System Code** **HIPPS Code**	~~Billing codes used when submitting claims to the MACs (previously FIs) for Medicare payment. Codes comprise the PDPM group calculated by the assessment followed by an indicator to indicate which assessment was completed.~~The 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.

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Chapter	Section	Page(s) in version 1.18.11	Change
App. A	—	A-10	**Health Literacy** The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
App. A	—	A-11	**Interdisciplinary Team** **IDT** A team that includes staff members from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners.
App. A	—	A-11	**Internet Quality Improvement and Evaluation System** **iQIES** The umbrella system that encompasses the MDS ~~and Swing Bed (SB) MDS~~ system and other provider-specific assessment collection systems, as well~~, other systems for~~ as survey and certification~~, and home health providers~~ data collection and storage. SNF/NF providers not utilizing proprietary software can complete and submit the MDS records in iQIES, as well as obtain MDS-related reports. Moved revised entry to correct alphabetical position in Glossary list

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Chapter	Section	Page(s) in version 1.18.11	Change	
App. A	—	A-11	**Interoperability**	A system's ability to exchange electronic health information with, and use electronic information from, other systems without special effort on the part of the user. Interoperability is further specified as health systems' ability to electronically send health information to, receive health information from, find health information in, integrate health information into, or health information from other electronic systems outside of their organizations.
App. A	—	A-12	**Invalid Record**	As defined by the MDS Correction Policy, a record that was accepted into iQIES ~~ASAP~~ that should not have been submitted. Invalid records are defined as: a test record submitted as production, a record for an event that did not occur, a record with the wrong resident identified or the wrong reason for assessment, or submission of an inappropriate non-required record.
App. A	—	A-12	~~**Java-Based Resident Assessment Validation and Entry System**~~ ~~**jRAVEN**~~	~~Data entry software supplied by CMS for nursing facilities and hospital swing beds to use to enter MDS assessment data.~~

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App. A	—	A-12	**Leave of Absence** **LOA** Leave of Absence (LOA), which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a: • Temporary home visit of at least one night; or • Therapeutic leave of at least one night; or • Hospital observation stay less than 24 hours and the hospital does not admit the resident.
App. A	—	A-13	~~**Login ID**~~ ~~A State-assigned facility identifier required to access QIES ASAP. This may or may not be the same as the Facility ID.~~
App. A	—	A-13	**Look-Back Period** ~~A timeframe defined by counting backwards from the ARD that is used when coding each item on the MDS.~~See Observation Period.
App. A	—	A-13	**Major Surgery** Generally, major surgery refers to a procedure that meets the following criteria: 1. The resident was an inpatient in an acute care hospital for at least 1 day in the 100 days prior to admission to the skilled nursing facility (SNF), **and** 2. The surgery carried some degree of risk to the resident's life or the potential for severe disability.

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App. A	—	A-14	**Medicare Covered-Stay** Skilled Nursing Facility stays billable to Medicare Part A ~~when specific requirements and criteria are met for an individual~~. Does not include stays billable to other payers (e.g., Medicare Advantage plans).
App. A	—	A-14	**Medicare Number ~~(or Comparable Railroad Insurance Number)~~** ~~A number assigned to an individual for participation in national health insurance program. The first 9 characters must be numbers. The Medicare Health Insurance number may be different from the resident's social security number (SSN). For example, many residents may receive Medicare benefits based on a spouse's Medicare eligibility.~~An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier is different from the resident's Social Security Number (SSN) and may contain both letters and numbers.
App. A	—	A-15	**National Provider Identifier NPI** A unique federal number that identifies providers of health care services. The NPI applies to the ~~nursing facility~~SNF/NFs for all of its residents.

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Chapter	Section	Page(s) in version 1.18.11	Change	
App. A	—	A-16	**Observation Period**	The time period over which an MDS assessment captures a resident's condition or status. A day begins at 12:00 a.m. and ends at 11:59 p.m.; the observation period must also cover this time period. An MDS assessment captures only occurrences during the observation period. In other words, if it did not occur during the observation period, it is not coded on the MDS. Also referred to as **Look-Back Period or Assessment Period**.
App. A	—	A-17	**Patient Health Questionnaire ~~9 Item~~** **PHQ-2 to 9©**	A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.
App. A	—	A-18	**Patient Driven Payment Model** **PDPM**	The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF) residents in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System. Effective beginning October 1, 2019, PDPM ~~will~~ replaced the ~~current~~Federal case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).
App. A	—	A-19	**Portal**	A secure online website that gives providers, residents, and others 24-hour access to personal health information from anywhere with an Internet connection.

Chapter	Section	Page(s) in version 1.18.11	Change		
App. A	—	A-19	**Private Home/ Apartment**		A noninstitutional community residential setting that can include houses, condominiums, or apartments in the community whether owned by the resident or another person, as well as retirement communities and independent housing for the elderly.
App. A	—	A-20	**Quality Improvement Network**	**QIN**	The Quality Improvement Organization (QIO) Program's 14 Quality Innovation Network-QIOs (QIN-QIOs) bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. By serving regions of two to six states each, QIN-QIOs are able to help best practices for better care spread more quickly, while still accommodating local conditions and cultural factors.
App. A	—	A-20	**Quality Improvement Organization**	**QIO**	A program administered by CMS that is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of ~~fifty-three~~ QIOs responsible for each U.S. State, territory, and the District of Columbia. Their mission is to ensure the quality, effectiveness, efficiency, and economy of health care services provided to Medicare beneficiaries.

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App. A	—	A-20	**Quality Measure** **QM**	Information derived from MDS data, that provides a numeric value to quality indicators. These data are available to the public as part of the Nursing Home Quality Initiative (NHQI) and SNF Quality Reporting Program (QRP) and are intended to provide objective measures for consumers to make informed decisions about the quality of care in ~~nursing facilities~~SNF/NFs.
App. A	—	A-21	**Rehabilitation Therapy**	Special health care services or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. These services or programs can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.
App. A	—	A-22	**Social Isolation**	An actual or perceived lack of contact with other people, such as living alone or residing in a remote area.
App. A	—	A-23	**Stress Incontinence**	Episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.

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App. A	—	A-23	**Submission Confirmation ~~Page~~**	The initial feedback generated by ~~the CMS MDS Assessment Submission and Processing System (ASAP)~~iQIES after an MDS data file is electronically submitted. This ~~page~~message acknowledges receipt of the submission file~~,~~ but does not examine the file for any warnings and/or errors. Warnings and/or errors are provided on the Final Validation Report.
App. A	—	A-24	**Submission Requirement**	**SUB_ REQ** A field in the MDS electronic record (A0410) that identifies the authority for data collection. CMS has authority to collect assessments for all residents (regardless of their payer source) who reside in Medicare- and/or Medicaid-certified units. States may or may not have regulatory authority to collect assessments for residents in non-certified units.
App. A	—	A-24	**Swing Bed**	A rural non-critical access hospital with fewer than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.

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App. A	—	A-24	**Therapeutic Diet**	A therapeutic diet is a diet intervention ~~ordered~~prescribed by a ~~health care~~physician or other authorized nonphysician practitioner that provides food or nutrients via oral, enteral, and parenteral routes as part of the treatment ~~for a~~of disease or clinical condition ~~manifesting an altered nutritional status~~, to modify, eliminate, decrease, or increase ~~certain substances~~identified micro- and macronutrients in the diet ~~(e.g., sodium, potassium)~~ (~~ADA~~Academy of Nutrition and Dietetics, 20~~11~~20)
App. A	—	A-25	**Transitional Living**	Settings that provide longer-term residential services offering professional support, education, and a stable living environment for individuals transitioning from situations such as homelessness, alcohol use disorder, and substance use disorder. Such settings afford safe living accommodations and services to support a successful transition to self-sufficient living.

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App. A	—	A-25	**Usual Performance**	The environment or situations encountered at a facility can have an impact on a resident's functional status. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance or worst performance, but rather, record the resident's usual performance.
App. A	—	A-25	~~**Worsening in Pressure Ulcer Status**~~	~~Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment determinations assigned to each stage; starting at the stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.~~
App. A	—	A-26	EHR	Electronic Health Record
App. A	—	A-26	EMR	Electronic Medical Record
App. A	—	A-27	~~FI~~	~~Fiscal Intermediary~~
App. A	—	A-27	HIE	Health Information Exchange
App. A	—	A-27	IDT	Interdisciplinary Team

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App. A	—	A-27	iQIES	Internet Quality Improvement and Evaluation System Moved revised entry to correct alphabetical position in Common Acronyms list
App. A	—	A-27	~~jRAVEN~~	~~Java-Based Resident Assessment Validation and Entry System~~
App. A	—	A-27	~~MDCN~~	~~Medicare Data Communications Network~~
App. A	—	A-27	NH	Nursing Home
App. A	—	A-27	~~OMRA~~	~~Other Medicare-required Assessment~~
App. A	—	A-27	~~OSA~~	~~Optional State Assessment~~
App. A	—	A-28	PHQ-2 to 9©	Patient Health Questionnaire ~~9-Item~~