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Preparing for the October 1, 2023 MDS Changes

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Information as of August 2023

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Objectives

- Review the major guidance changes to the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Version 1.18.11
- Explain changes to the:
  - Intent
  - Rationale
  - Steps for assessment
  - Coding instructions
  - Coding tips for selected data elements

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Commonly Used Acronyms

ARD	Assessment Reference Date	MDS	Minimum Data Set
BIMS	Brief Interview for Mental Status	OBRA	Omnibus Budget Reconciliation Act
CAA	Care Area Assessment	OSA	Optional State Assessment
CAT	Care Area Trigger	PAC	Post Acute Care
CMS	Centers for Medicare & Medicaid Services	PHQ	Patient Health Questionnaire
DC	Discharge	PPS	Prospective Payment System
LOA	Leave of Absence	QM	Quality Measure
iQIES	Internet Quality Improvement and Evaluation System	RAI	Resident Assessment Instrument
ID/DD	Intellectual Disability/Developmental Disability	SNF	Skilled Nursing Facility

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New Structure and Content

Revision of the MDS and guidance manual:

- Structural data element redesign
- Manual text updates

To align data elements and guidance across the post-acute care (PAC) settings:

- Standardized patient assessment data elements added to the MDS
- Some existing MDS data elements used for standardization did not require revision and are now used across all PAC settings

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Global Changes to the MDS 3.0 RAI Manual

- Content updated with gender neutral language
- Minor updates to working to enhance understanding
- Coding examples modified to improve clarity
- Quality Improvement and Evaluation System (QIES) changed to iQIES
- Revision made pertaining to legal/proxy information for family member, significant other, and/or guardian/legally authorized representative to provide consistency

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Minor Updates

- **Revisions to Chapter Guidance**
  - Chapters 1, 2, and 4
- **Revised Data Elements and/or new/revised guidance in Chapter 3**
  - Section A
  - Section B
  - Section F
  - Section H
  - Section I
  - Section M
  - Section X

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Chapter 1 Changes

- Removal of specific people and organizations that have contributed to the development and revisions of the RAI manual
- Adoption of the phrase “data elements” to describe the items within the MDS
- Defining of the “Utilization Guidelines” as the RAI Manual
- Update to the name of Nursing Home Compare to Care Compare
- Updates to the Section and Intent table and Legal Notices

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Chapter 2 Changes

- Swing bed – clarification that there are in non-critical access hospitals (non-CAH)
- Clarification on responsibilities when there is a change of ownership
- LOA – Significant Change in Status Assessment may be necessary after an LOA
- OBRA and PPS discharge clarification – the assessments must be combined with the criteria were met with the ARD equaling the DC date at A2000

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Chapter 3 Changes

- Terminology of CMS Regional Offices changed to a more general locations
- References to Section G changed to GG
  - ADL Reference kept throughout, and ADL definition added to Section GG
- Updates to each section
- Option for Optional State Assessment removed
  - CMS released a separate item set and guidance on the MDS webpage
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual
  - Scroll to the Downloads Section and click on Final OSA Manual...
- Decision to use this will be at the state level
- Not a CMS-required assessment
- Will not be able to be combined with a CMS-required assessment

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Chapter 4 Changes

- **Care Area Trigger (CAT) Logic Tables – Revised**
  - Activities of Daily Living (ADL) Functional/Rehabilitation Potential (GG0130 and GG0170)
  - Urinary Incontinence and Indwelling Catheter (GG0130 and GG0170)
  - Pressure Ulcer/Injury (GG0130 and GG0170)
  - Psychosocial Well-Being, Mood State, and Activities (D0150 and D0160)
  - Falls and Psychotropic Medication Use (N0415)
  - Nutritional Status, Feeding Tubes, and Dehydration/Fluid Maintenance (K0520)
  - Pain (J0410, J0510 and J0530
  - Return to Community Referral (Q0610)

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Chapter 5 and 6 Changes

- **Chapter 5:** Manual Assessment Correction/Deletion request – an added reason
  - Record submitted was not for OBRA or Medicare Part A purposes
- **Chapter 6:** Updates to items numbers in PDPM component calculation, no changes to the actual calculations

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Appendix A:

Glossary and Common Acronyms Additions

- Active Discharge Plan
- Assisted Living
- Board and Care
- Critical Access Hospital
- Electronic Health Record
- Electronic Medical Record
- Group Home
- Health Information Exchange
- Health Literacy
- Interdisciplinary Team
- Interoperability
- Leave of Absence

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Appendix A:

Glossary and Common Acronyms Additions (continued)

- Major Surgery
- Observation Period
- Portal
- Private Home/Apartment
- Quality Improvement Network
- Rehabilitation Therapy
- Social Isolation
- Stress Incontinence
- Transitional Living
- Usual Performance

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Standardized Patient Assessment Data Elements

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain SPADEs for PAC settings.
  - Home Health Agencies
  - Inpatient rehabilitation facilities
  - Long-Term care hospitals
  - Skilled nursing facilities
- The goals of implementing cross-setting SPADEs are to facilitate care coordination and interoperability and to improve Medicare beneficiary outcomes.

- Ethnicity
- Race
- Language
- Transportation
- Health Literacy
- Social Isolation

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Section A: Identification Information

- **Intent** *// to obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident, potential care needs including access to transportation, and they home in which they reside.*
- **A0300:** Optional State Assessment data element as well as all associated guidance was removed.
- **A0310:** Type of Assessment instructional guidance revised, for all federally required assessments and records as well as all PPS assessments

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A1005 Ethnicity (SPADES)

- Information gathering must start with the resident.
- If the resident is unable to answer, others (*family, significant other, or legal guardian*) may be asked
- If other are not available, the medical record may be used to determine
- If the resident declines to respond, other resources cannot be used to answer the question

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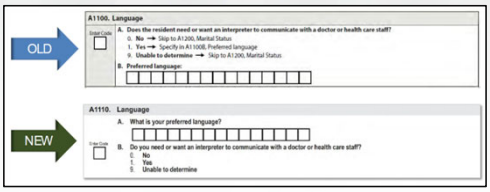
A1110 Language

- The prior Language data element (A1100) is renumbered as A1110, and the response codes have been flipped and reworded:



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A1010 Race (SPADEs)

- Information gathering must ***start with the resident***
- If the resident is unable to answer, others (family, significant other, or legal guardian) may be asked
- If others are not available, the medical record may be used to determine
- If the ***resident declines to respond, other resources cannot be used*** to answer the question

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A1010 Language (SPADEs)

- Enter the preferred language the resident primarily speaks or understands after interviewing the *resident and family, significant other an/or guardian/legally authorized representative and/or reviewing the medical record*
- If the resident, family member, significant other, guardian/legally authorized representative and/or medical record documentation cannot or does not identify preferred language, enter a dash (-) in the first box

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A1250 Transportation (SPADEs)

- Information gathering must start with the resident
- If the resident is unable to answer, others (family, significant other, or legal guardian) may be asked
- If others are not available, the medical record may be used to determine
- If the resident declines to respond, other resources cannot be used to answer the question
- Completed at the start of the Medicare stay (5-day PPS) and at the end of the Medicare stay with a planned discharge

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A 1600 Entry Date

- New – In the case of an interrupted stay, the return date (i.e., date of continuation of the Medicare Part A stay in the same SNF) is entered at A1600:

Most Recent Admission/Entry or Reentry into this Facility
A1600. Entry Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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A1805 Entered From/A2105 Discharge Status

- **Additional definition added to settings**
  - Acute hospital replaced with Short-Term General Hospital (acute hospital/IPPS)
  - Psychiatric hospital replaced with Inpatient Psychiatric Facility
  - ID/DD Facility replaced by Intermediate Care Facility
- **Added settings**
  - **Nursing Home**
    - Skilled Nursing Facility – (SNF/Swing Bed)
    - Nursing Home (Long-term care facility)
  - **Hospice**
    - Hospice (home/non-institutional)
    - Hospice (institutional facility)
  - **Critical Access Hospital**
  - **Home under organized Home Health services organization**
    - Only skilled services from a home care agency
- **Option for not listed added**

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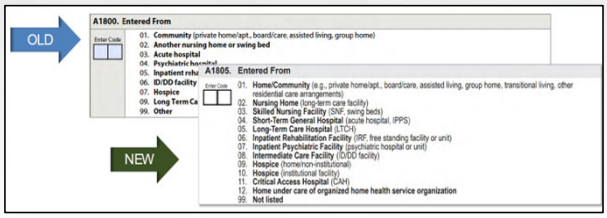
A1805 Entered From

- This data element was aligned across most PAC settings and renumbered:



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A2121 and A2123 Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

- **Providing the current reconciled medication list at the time of transfer or discharge can be accomplished by any means, including**
  - Mail
  - Electronically
  - Verbally
  - Common HER
  - Access to portal
  - *These were added to meet requirements for SNF Quality Reporting Program Transfer of Health Information Measures, and ask about a process that has or has not been completed in the facility*

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Considerations for Important Medication List Content

- The following information on the important content that may be included in a reconciled medication list is provided as guidance.
- This guidance does not dictate what information should be included in the facility's current reconciled medication list in order to code 1.
- Yes, that a current reconciled medication list was provided to the subsequent provider, the completeness of this reconciled medication list is left to the discretion of the providers who are coordinating care with the resident.
- A reconciled medication list often includes important information about the resident including their name, date of birth, active diagnoses, known medication and other allergies along with each medication administration, frequency or timing, purpose/indication and any special instructions

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Route of Current Reconciled Medication List Transmissions A2122, Subsequent Provider and A2124, Resident

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

↓ Check all that apply	Route of Transmission
☐ A.	**Electronic Health Record** (e.g., electronic access to patient portal)
☐ B.	**Health Information Exchange**
☐ C.	**Verbal** (e.g., in-person, telephone, video conferencing)
☐ D.	**Paper-based** (e.g., fax, copies, printouts)
☐ E.	**Other methods** (e.g., texting, email, CDs)

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A2000 / Discharge Data

- The name of this data element has been changed from "OBRA Discharge Date" to simply "Discharge Date"
- Two new Coding Tips were added related to the completion of the Discharge assessment at the end of a Medicare Part A stay.
  - If the stay ends on or one day prior to the day of discharge from the facility, the PPS Discharge assessment may be combined with the OBRA Discharge assessment. If combined, the ARD (A2300) must be equal to the day of discharge (A2000)
  - If the stay ends, but the resident remains in the facility, the ARD (A2300) must be equal to the last Medicare Part A covered day. The PPS Discharge assessment may be combined with most OBRA-required assessments when requirements for all assessments are met.

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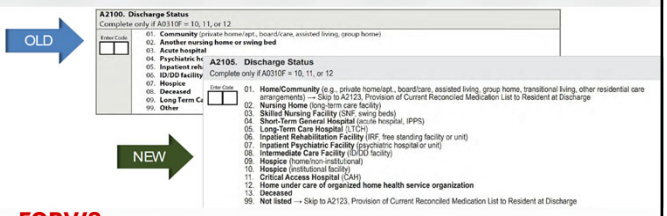
A2105. Discharge Status

- This data element was aligned across some PAC settings and renumbered:



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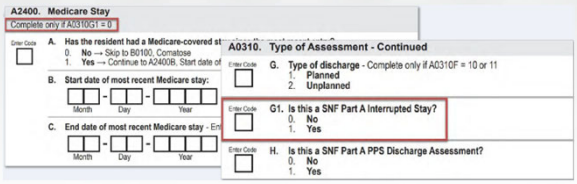
A2400 Medicare Stay – Coding Tips

Items A2400A-A2400C are not active when the OBRA Discharge assessment indicates the resident has had an interrupted stay (A0310G1 = 1)



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B0200 Hearing and B1000 Vision

- Other PAC settings adopted B0200 Hearing and B1000 Vision as standardized patient assessment data elements.
- These data elements were not revised for SNF, but some changes were made to guidance to enhance clarity and new examples were added for both data elements.

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B1300 Health Literacy

- This is a resident self-report item, no other resources should be used to identify the response even if the resident is unable to respond.
- How often do you need to have someone help you read instructions, or other written material from your doctor or pharmacy?
  - 0. Never
  - 1. Rarely
  - 2. Sometimes
  - 3. Often
  - 4. Always
  - 7. Resident declines to respond
  - 8. Resident unable to respond

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Section C Updates

- BIMS – Definition box of Complete Interview added: The BIMS is considered complete if the resident attempted and provided relevant answers to at least four of the questions included in C0200-C0400C. Relevant answers do not have to be correct but do need to be related to the question that was asked.
- BIMS clarification on the use of code 0
  - Three different types of responses represented by code of 0
  - Incorrect, not answered, nonsensical
    - Tip to track responses to aid in proper calculation of summary score

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D0100: Should Resident Mood Interview Be Conducted?

- Instructions to complete the day of or the day before the ARD removed
- Clarified that if an interpreter was wanted or needed but not available, the gateway question should be answered no, and the staff assessment would be completed

D0150: Should Resident Mood Interview Be Conducted?

- Instructions to complete the day of or the day before the ARD and look-back period of 14 days removed

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D0150 Resident Mood Interview (PHQ 2-9)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   - 0. **No** (enter 0 in column 2)
   - 1. **Yes** (enter 0-3 in column 2)
   - 9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   - 0. **Never or 1 day**
   - 1. **2-6 days** (several days)
   - 2. **7-11 days** (half or more of the days)
   - 3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐

If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.

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More Section D Updates

- **D0150 should the resident mood interview be conducted?**
  - Additional instruction added to coding tips page D-6
- **D0160 Total Severity Score**
  - Total severity score can be calculated from PHQ-2
    - If both D0150A2 and D0150B2 are scored 0 or 1
  - Severity of depressive syndrome is suggested based on completion of full PHQ-9
  - Additional language added to planning for care page D-10 to D-11
  - Additional language added to coding instructions page D-11
- **D0500 Staff assessment of resident mood**
  - 14-day look-back removed
  - Added instruction "Conduct the interviews during the 7-day look-back period based on the ARD"

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D0700 Social Isolation (SPADEs)

- This is a resident self-report item, no other resource should be used to identify the response even if the resident is unable to respond
- Social Isolation refers to an actual or perceived lack of contact with other people, such as living along or residing in a remote area

D0700. Social Isolation

Enter Code ☐

How often do you feel lonely or isolated from those around you?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

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Section F Interview for Daily Activity Preferences

- Added Steps for Assessment:

  There may be times when, due to medical or psychiatric conditions, a resident has difficulty communicating and understanding. When conducting resident interviews, providers are to assess and use their clinical judgment to determine the best time in which to attempt to conduct the resident interview. Providers are to attempt to conduct the interview with all conscious residents.

  The determination as to whether or not a resident interview is conducted is not based on the response to item B0700, Makes Self Understood. Instead, the resident interview is attempted, and is only terminated based on the response or lack of response to the resident interview questions/statements according to the coding instructions provided for the interview which would render the interview incomplete.

- If the resident is unable to complete the resident interview, attempt to conduct the interview with a family member or significant other. If neither a family member nor significant other is available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.

- Review Language item (A1110) to determine whether or not the resident needs or wants an interpreter.

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SURPRISE….

Section G is GONE!

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GG0115 Functional Limitation in Range of Motion / GG0120 Mobility Devices

- Both are recycled from Section G – instructions are the same except for the references to the new numbering

GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

Coding:
0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

↓ **Enter Codes in Boxes**

- ☐ **A. Upper extremity** (shoulder, elbow, wrist, hand)
- ☐ **B. Lower extremity** (hip, knee, ankle, foot)

GG0120. Mobility Devices

↓ **Check all that were normally used in the last 7 days**

- ☐ **A. Cane/crutch**
- ☐ **B. Walker**
- ☐ **C. Wheelchair** (manual or electric)
- ☐ **D. Limb prosthesis**
- ☐ **Z. None of the above** were used

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GG0130 Self-Care/GG0170 Mobility

- Column 5 added OBRA/Interim
  - Includes only non-admission OBRA assessments or interim payment assessments for PPS
- Additional language added to Health-related Quality of Life page GG-14
  - Adapted from section G language
- Definition of ADL added page GG-14
- New Planning for Care guidance page GG-14
  - Adapted from section G language

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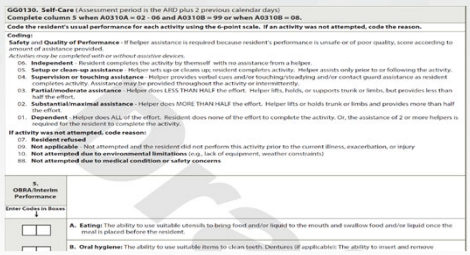
GG0130 Self-Care (OBRA/Interim)



GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)
Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.
Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. OBRA/Interim Performance Enter Codes in Boxes ↓	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove

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GG0130 Self-Care/GG0170 Mobility

- Definition added for "Prior to benefit of services"
  - *Prior to the provision of any care by facility staff that would result in more independent coding*
- **Clarification** – additional coding instructions
  - Code 04 – Supervision – clarified if only verbal cueing
  - Code 01 – Dependent – clarification of the use of 2 helpers
    - Second helper providing supervision and standby assist
    - Second helper managing equipment
- **Clarification** – additional coding tips
  - CMS does not provide an exhaustive list for assistive devices when coding GG0130 or GG0170
  - Items used strictly during therapy sessions should be excluded (e.g., parallel bars, exoskeleton, or overhead track and harness systems)

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Other GG Updates

- Eating: Coding tip clarifications and additions (GG-22)
- Toileting Hygiene: Coding tips clarification (GG-25)
- Shower/Bathe Self: Coding tips clarification (GG-26)
- Upper body dressing, Lower body dressing and putting on and taking off footwear: Coding tip added (GG-28)
- GG0130I Personal Hygiene (recycled from Section G): for OBRA not completed with stand alone PPS assessments
- Roll left to right, lying to sitting on side of bed, sit to stand, chair/bed to Chair Transfer, toilet transfer: Coding tips added (GG49 – 56)
- Tub/shower transfer: for OBRA not completed with stand alone PPS assessments (GG-58)
- Car Transfer: Coding tip clarification and additions (GG-59)
- Walking Items: Coding tips added (GG-60)

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Section H: Bowel and Bladder

- Revised coding tip: Do not include one-time catheterization(s) for urine specimen collection or other diagnostic exams (e.g., to measure post-void residual) during look-back period as intermittent catheterization.
- New Definition: Stress incontinence
  - Episodes of small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, or lifting heavy objects, or exercise.

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I0020 Primary Medical Condition Category

- Revised:

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Indicate the resident's primary medical condition category that best describes the primary reason for admission

Enter Code

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions

I0020B. ICD Code

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Section J: Health Conditions

- J0300 – J0600 Planning for Care additional information discussing nonpharmacological and non-opioid approaches to pain management (J-7)
- Steps for assessment – language of completion preferred on or day before ARD removed but still encourages interviews to be conducted close to the end of the look-back period
- Clarified that if an interpreter was wanted or needed but not available, the gateway question would be answered no, and the staff assessment would be completed.

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J0410 Pain Frequency – New Item Number

J0410. Pain Frequency

Enter Code ☐

Ask resident: "*How much of the time have you experienced pain or hurting over the last 5 days?*"

1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
9. Unable to answer

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J0510, Pain Effect on Sleep

- Question slightly reworded from prior version
- No longer a yes-no question, changed to frequencies

J0510. Pain Effect on Sleep

Enter Code ☐

Ask resident: "*Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?*"

1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

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J0520, Pain Interference with Therapy Activities – New Item:

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask resident: *"Over the past 5 days, **how often have you limited your participation in rehabilitation therapy sessions due to pain?"***

0. Does not apply - I have not received rehabilitation therapy in the past 5 days
1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

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J0530 Pain Interference with Day-to-Day Activities

- Slightly reworded
- No longer a yes-no question – changed to frequencies

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask resident: *"Over the past 5 days, **how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***

1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

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K0520 Nutritional Approaches

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

1. **On Admission** Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident** Performed ***while NOT a resident*** of this facility and within the ***last 7 days.*** Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
	Check all that apply			
A. **Parenteral/IV feeding**	☐	☐	☐	☐
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐		☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z. **None of the above**	☐	☐	☐	☐

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Section M: Skin Conditions

- New Coding Tip
  - Skin changes at end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.

  Revised

- For each pressure ulcer, determine the deepest anatomical stage. At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. Do not reverse or back - stage. Consider current and historical levels of tissue involvement.

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Section M Skin Conditions

- Revised
  - Review the history of each pressure ulcer in the medical record. If the stageable pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage until healed unless it becomes unstageable. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.
  - Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed unless it becomes unstageable. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool.
  - A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.

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Section M Skin Conditions

- New
- If a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury is coded as “present on admission.”
- Additional changes in this section include updated examples and one new example added for M0300G. Unstageable Pressure Ulcers Related to Deep Tissue Injury.

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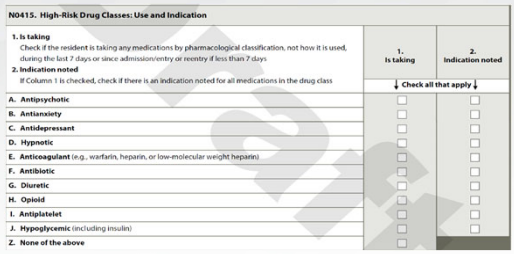
N0415, High-Risk Drug Classes: Use and Indication



N0415. High-Risk Drug Classes: Use and Indication

1. Is taking Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days 2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking	2. Indication noted
	↓ Check all that apply ↓	
A. Antipsychotic	☐	☐
B. Antianxiety	☐	☐
C. Antidepressant	☐	☐
D. Hypnotic	☐	☐
E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F. Antibiotic	☐	☐
G. Diuretic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

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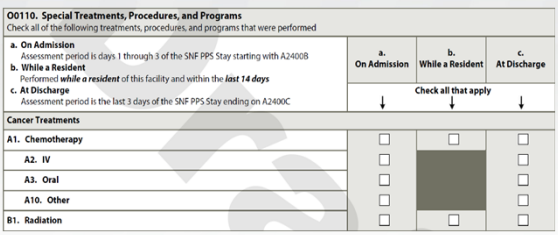
O0110, Special Treatments, Procedures, and Programs



O0110. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that were performed

a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B b. While a Resident Performed ***while a resident*** of this facility and within the ***last 14 days*** c. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C	a. On Admission	b. While a Resident	c. At Discharge
	↓	Check all that apply ↓	↓
Cancer Treatments			
A1. Chemotherapy	☐	☐	☐
A2. IV	☐		☐
A3. Oral	☐		☐
A10. Other	☐		☐
B1. Radiation	☐	☐	☐

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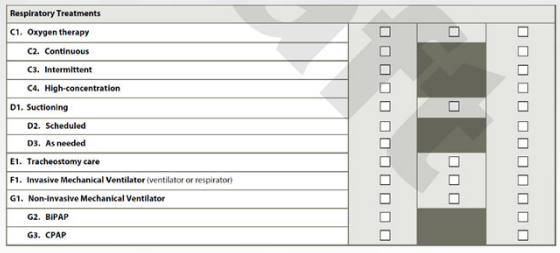
O0110 Special Treatments, Procedures, and Programs



Respiratory Treatments			
C1. Oxygen therapy	☐	☐	☐
C2. Continuous	☐		☐
C3. Intermittent	☐		☐
C4. High-concentration	☐		☐
D1. Suctioning	☐	☐	☐
D2. Scheduled	☐		☐
D3. As needed	☐		☐
E1. Tracheostomy care	☐	☐	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐	☐
G1. Non-invasive Mechanical Ventilator	☐	☐	☐
G2. BiPAP	☐		☐
G3. CPAP	☐		☐

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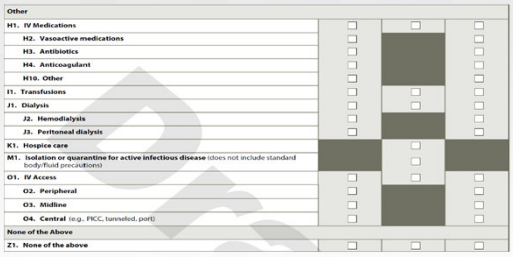
O0110 Special Treatments, Procedures, and Programs



Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐		☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐		☐
J3. Peritoneal dialysis	☐		☐
K1. Hospice care		☐	
M1. Isolation or quarantine for active infectious disease (does not include standard body fluid precautions)		☐	
O1. IV Access	☐	☐	☐
O2. Peripheral	☐		☐
O3. Midline	☐		☐
O4. Central (e.g., PICC, tunneled, port)	☐		☐
None of the Above			
Z1. None of the above	☐	☐	☐

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More Section O Updates:

- O0400 Minutes of therapy (O-24)
  - In the case of an interrupted stay, the therapy start date entered in O0400A5, O0400B5, and/or O0400C5 must reflect a date on or after the date in A2400B
- O0425 Part A Therapies (O-41)
  - In the case of an interrupted stay, code medically necessary therapy that occurred during the entire current Medicare Part A PPS stay that meet the criteria
- O0600, Physician Examinations and O0700, Physician orders removed from item set and manual
  - Are on the OSA item set for states using the Optional State Assessment

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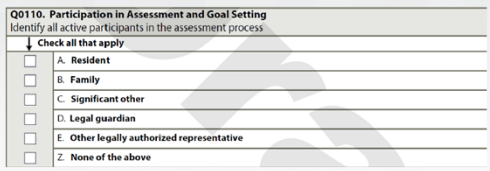
Q0110 Participation in Assessment and Goal Setting



Q0110. Participation in Assessment and Goal Setting
Identify all active participants in the assessment process

↓ Check all that apply	
☐	A. Resident
☐	B. Family
☐	C. Significant other
☐	D. Legal guardian
☐	E. Other legally authorized representative
☐	Z. None of the above

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Q0400 Active Discharge Plan

- ACTIVE DISCHARGE PLANNING: *An active discharge plan means a plan that is currently being implemented. The resident's care plan has current goals to make specific arrangement 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 (Q0500B) and then referred to the LCA accordingly. Referrals to the LCA are recommended as part of many residents' discharge plan. These referrals are a helpful source of information for residents and facilities in informing the discharge planning process

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Q0610 // Has a referral been made to the Local Contact Agency (LCA)?

- Coding instructions clarified (Q-22)

Q0610. Referral	
Enter Code ☐	A. Has a referral been made to the Local Contact Agency (LCA)? 0. No 1. Yes

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Q0620, Reason Referral to LCA Not Made - New

- Health-Related Quality of Life and Planning for Care – Understanding the reason that referrals to the LCA were not made allows for comprehensive planning by the IDT in conjunction with the resident and their family

Q0620. Reason Referral to Local Contact Agency (LCA) Not Made Complete only if Q0610 = 0	
Enter Code ☐	Indicate reason why referral to LCA was not made 1. LCA unknown 2. Referral previously made 3. Referral not wanted 4. Discharge date 3 or fewer months away 5. Discharge date more than 3 months away

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Section X Correction Request

- Revised
  - X0570 Optional State Assessment (A0300A/B on existing record to be modified/inactivated) was removed due to the removal of A0300. Optional State Assessment
  - X0900D Item Coding Error
    - Second bullet revised:

- An item coding error includes any error made coding an MDS item (for exceptions when certain items may not be modified, see Chapter 5), such as choosing an incorrect code for the Functional Abilities – Mobility item GG0170A, Roll left and right (e.g., choosing a code of "02" for a resident who requires supervision and should be coded as "04") . Item coding errors may result when an assessor makes an incorrect judgment or misunderstands the RAI coding instructions.

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CMS Timeline for MDS Updates and Training

- **CMS Updates**
  - May 2023
    - Final MDS data specifications
  - August 2023
    - Final RAI User's Manual

- **CMS Training**
  - May 2023
    - Part 1 – Virtual training – recorded videos – Live Now
    - https://www.youtube.com/watch?v=y-K-nWW2hhA&list=PLaV7m2-zFKphoXW6cc3NwUfxra0A1LYDi
  - June 23, 2023
    - Part 2 – Live virtual workshop with coding practice from what was learned in Part 1
    - Registration open

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Questions

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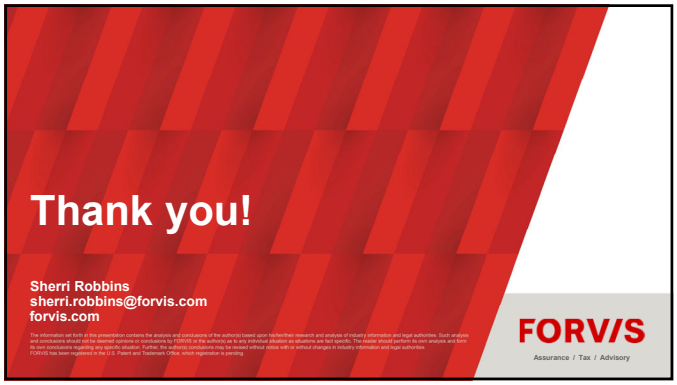
Thank you!
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