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# SNF Virtual Training Program – Part 1

## Understanding Changes to the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual

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# Objectives

- Identify the new and revised MDS items and guidance, effective October 1, 2023.
- Summarize changes in the RAI Manual.

# MDS 3.0: 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.

Refer to Chapter 3: Overview to the Item-By-Item Guide to the MDS 3.0 for additional information.



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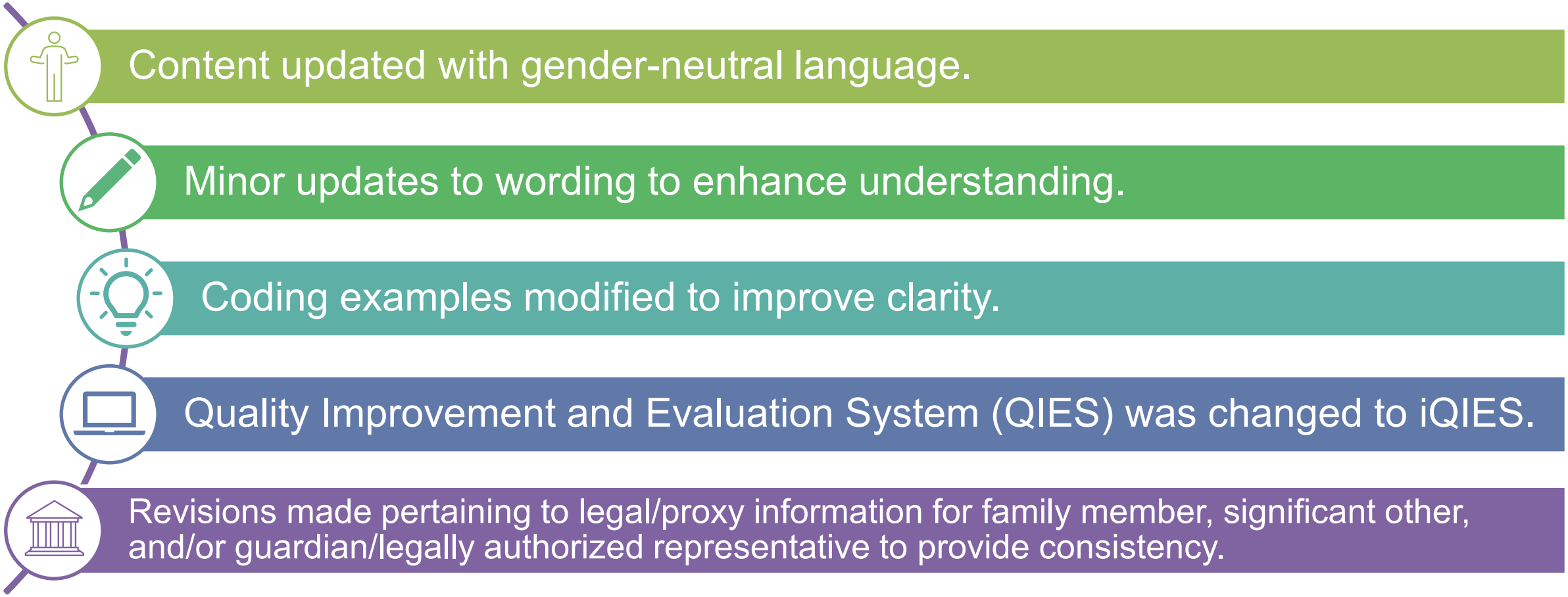
# Global Changes to the MDS 3.0 RAI Manual



# Review of Minor Updates

Revisions to Chapter Guidance:

Chapters 1, 2, and 4.

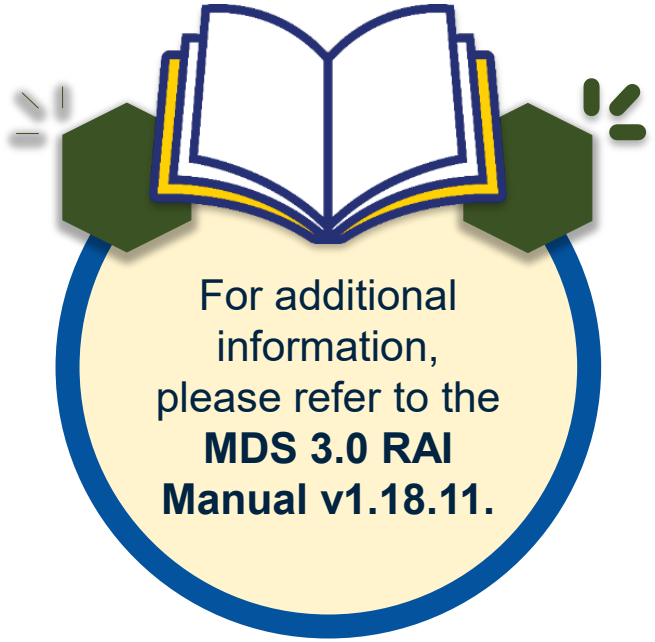
Revised Data Elements and/or New/Revised Guidance in Chapter 3:

- Section A
- Section B
- Section F
- Section H
- Section I
- Section M
- Section X

# Chapter 1: Resident Assessment Instrument

Changes made in Chapter 1 include:

- Removal of names 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.

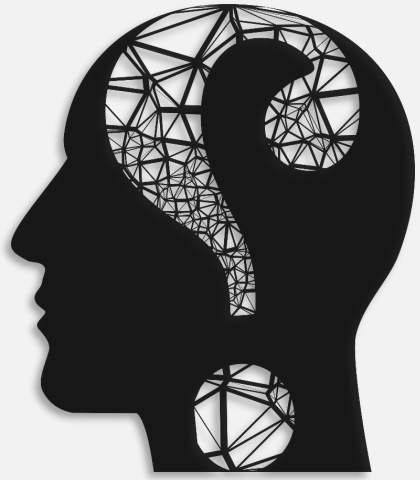


# Chapter 2: Assessments for the Resident Assessment Instrument (RAI)

REVISED

## 2.3 Responsibilities of Nursing Homes for Completing Assessments

When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an **anticipated return** to the facility, the evacuating facility should contact their CMS Location (formerly known as Regional Office), State Agency, and Medicare Administrative Contractor (MAC) for guidance.



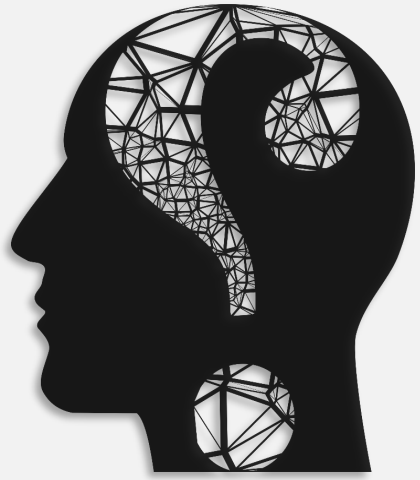
# Chapter 2: Assessments for the Resident Assessment Instrument (RAI) (cont.)

REVISED

## 2.5 Assessment Types and Definitions
## Assessment Reference Date (ARD) and Observation Period

ARD – Refers to specific endpoint for the observation (or ”look-back”) periods in the MDS assessment process.

Observation (Look-Back, Assessment) Period – is time period over which the resident’s condition or status is captured by the MDS assessment.



# Chapter 4: Care Area Assessment Process and Care Planning


The following Care Area Trigger (CAT) Logic Tables were revised to reflect changes made to associated data elements:

- 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).



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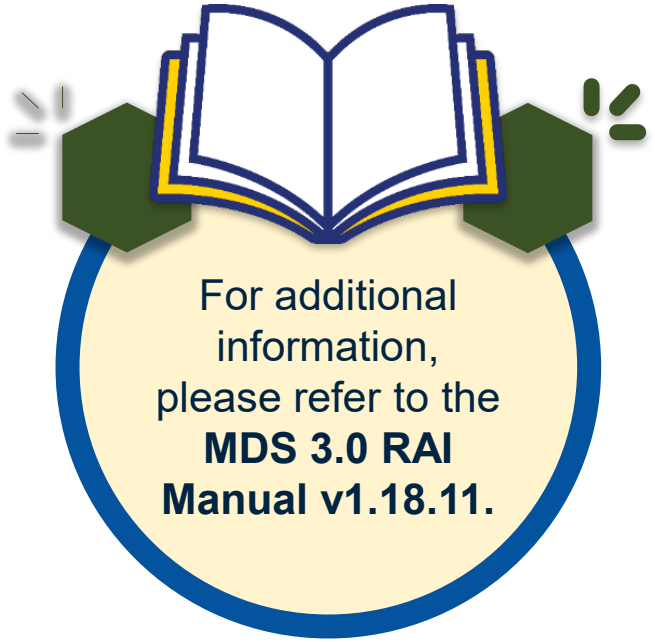
# Chapter 4: Care Area Assessment Process and Care Planning (cont.)

REVISED

- 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).



Section A: Identification Information

Section B: Hearing, Speech, and Vision

Section F: Preferences for Customary Routines and Activities

Section H: Bowel and Bladder

Section I: Active Diagnoses

Section M: Skin Conditions

Section X: Correction Request

# Section A: Identification Information

# Section A: Identification Information

The intent of this section is 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 the home in which they reside.

# A0300. Optional State Assessment and A0310. Type of Assessment


- 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.

# A1110. Language

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

OLD

**A1100. Language**

Enter Code ☐

**A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?**

0. **No** → Skip to A1200, Marital Status
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine** → Skip to A1200, Marital Status

**B. Preferred language:**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

NEW

**A1110. Language**

**A. What is your preferred language?**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Enter Code ☐

**B. Do you need or want an interpreter to communicate with a doctor or health care staff?**

0. **No**
1. **Yes**
9. **Unable to determine**

# A1110: Item Rationale


REVISED

## Health-related Quality of Life

- Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can lead to social isolation, depression, resident safety issues, and unmet needs.
- Language barriers can interfere with accurate assessment.

## Planning for Care

- When a resident needs or wants interpreter services, the nursing home must ensure that an interpreter is available.

# A1110: Steps for Assessment


1. Ask for the resident's preferred language.
2. Ask the resident if they need or want an interpreter to communicate with a doctor or health care staff.
3. If the resident – even with the assistance of an interpreter – is unable to respond, a family member, significant other, and/or guardian/legally authorized representative should be asked.
4. If neither the resident nor a family member, significant other, nor guardian/legally authorized representative source is able to provide a response for this item, medical documentation may be used.
5. It is acceptable for a family member, significant other, and/or legally authorized representative to be the interpreter if the resident is comfortable with it and if the family member, significant other, and/or guardian/legally authorized representative will translate exactly what the resident says without providing their interpretation.

# A1110A. What Is Your Preferred Language?

REVISED


- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, significant other and/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. A dash indicates “no information.” CMS expects dash use to be a rare occurrence.

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# A1110B. Do You Need or Want an Interpreter to Communicate With a Doctor or Health Care Staff?

REVISED

- **Code 0, No:** if the resident (family, significant other, guardian/legally authorized representative or medical record) indicates there is no need or want of an interpreter to communicate with a doctor or health care staff.
- **Code 1, Yes:** if the resident (family, significant other, guardian/legally authorized representative or medical record) indicates the need or want of an interpreter to communicate with a doctor or health care staff. Ensure that preferred language is indicated.
- **Code 9, Unable to determine:** if the resident is unable or declines to respond or any available source (family, significant other, guardian/legally authorized representative or medical record) cannot or does not identify the need or want of an interpreter.



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# A1600. Entry Date


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

**Most Recent Admission/Entry or Reentry into this Facility**

**A1600. Entry Date**

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

# A1805. Entered From

This data element was aligned across most PAC settings and renumbered.

OLD

**A1800. Entered From**

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient reha**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Ca**
99. **Other**

NEW

**A1805. Entered From**

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

# A1805. Entered From – Intent

REVISED

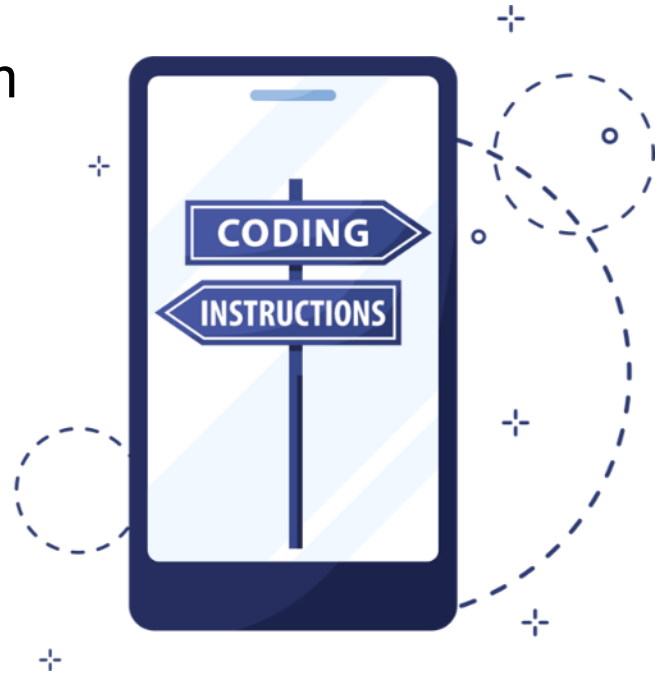
**Item Rationale:** Knowing the setting the individual was in immediately prior to facility admission/entry or reentry informs the delivery of services and care planning that the resident receives during their stay and may also inform discharge planning. See the Glossary and Common Acronyms in Appendix A for additional descriptions of these settings.

# A1805. Entered From – Coding Instructions

REVISED

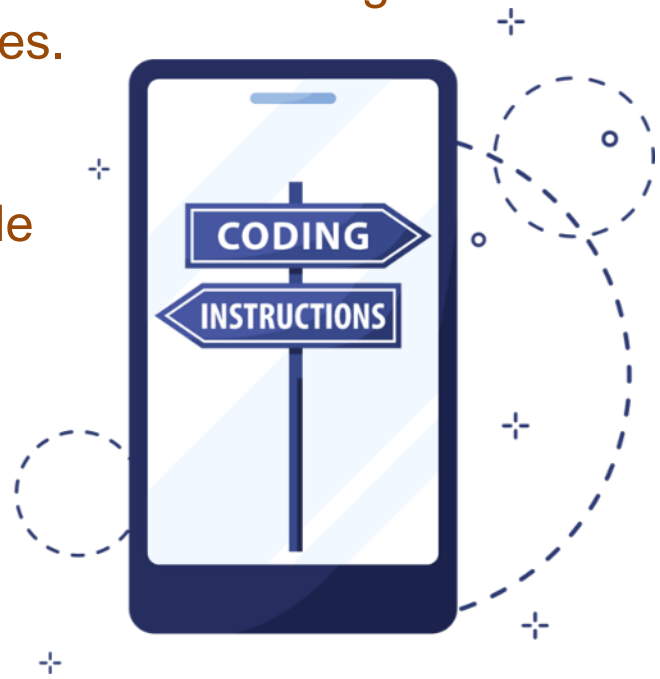
Enter the two-digit code that best describes the setting the resident was in immediately preceding this admission/entry or reentry.

- **Code 01, Home/Community:** if the resident was admitted from a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly.
- **Code 02, Nursing Home (long-term care facility):** if the resident was admitted from an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability.



# A1805. Entered From – Coding Instructions (cont. 1)

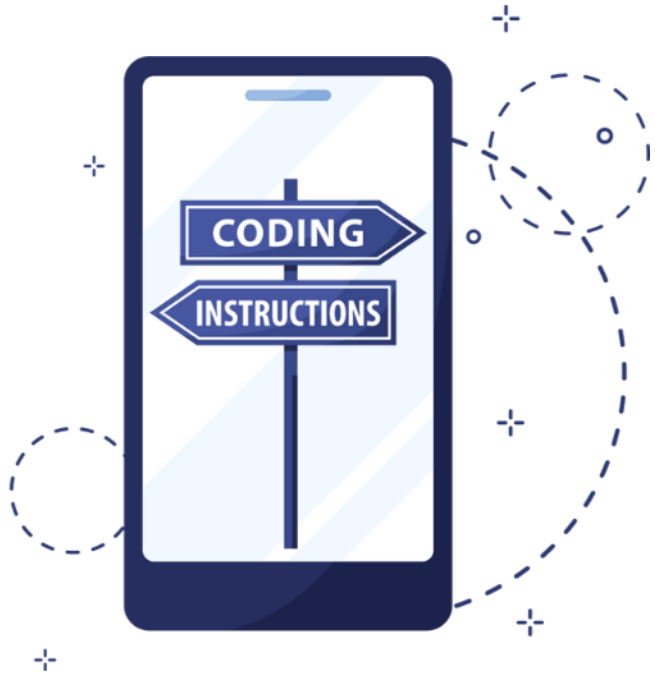

- **Code 03, Skilled Nursing Facility (SNF, swing bed):** if the resident was admitted from a nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category also includes residents admitted from a SNF swing bed in a swing bed hospital. A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide posthospital SNF care and meets certain requirements.
- **Code 04, Short-Term General Hospital (acute hospital/IPPS):** if the resident was admitted from a hospital that is contracted with Medicare to provide acute inpatient care and accepts a predetermined rate as payment in full.
- **Code 05, Long-Term Care Hospital (LTCH):** if the resident was admitted from a Medicare certified acute care hospital that focuses on patients who stay, on average, more than 25 days. Most patients in LTCHs are chronically and critically ill and have been transferred there from an intensive or critical-care unit.



# A1805. Entered From – Coding Instructions (cont. 2)

REVISED

- **Code 06, Inpatient Rehabilitation Facility (IRF, free standing facility or unit):** if the resident was admitted from a rehabilitation hospital or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients. This category also includes residents admitted from a rehabilitation unit of a critical access hospital.
- **Code 07, Inpatient Psychiatric Facility (psychiatric hospital or unit):** if the resident was admitted from an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. This category also includes residents admitted from a psychiatric unit of a critical access hospital.
- **Code 08, Intermediate Care Facility (ID/DD):** if the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals with intellectual disabilities (ID) or developmental disabilities (DD).



# A1805. Entered From – Coding Instructions (cont. 3)


- **Code 09, Hospice (home/non-institutional):** if the resident was admitted from a community-based program for terminally ill persons.
- **Code 10, Hospice (institutional facility):** if the resident was admitted from an inpatient program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based or inpatient hospice programs.
- **Code 11, Critical Access Hospital (CAH):** if the resident was admitted from a Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all of the criteria to be designated by CMS as a CAH and was receiving acute care services from the CAH at the time of discharge.
- **Code 12, Home under care of organized home health service organization:** if the resident was admitted from home under care of an organized home health service organization. This includes only skilled services provided by a home health agency.
- **Code 99, Not listed:** if the resident was admitted from none of the above.

# A1805. Entered From – Coding Tips

CODING TIPS

If an individual was enrolled in a home-based hospice program enter **09, Hospice**, instead of **01, Home/Community**.

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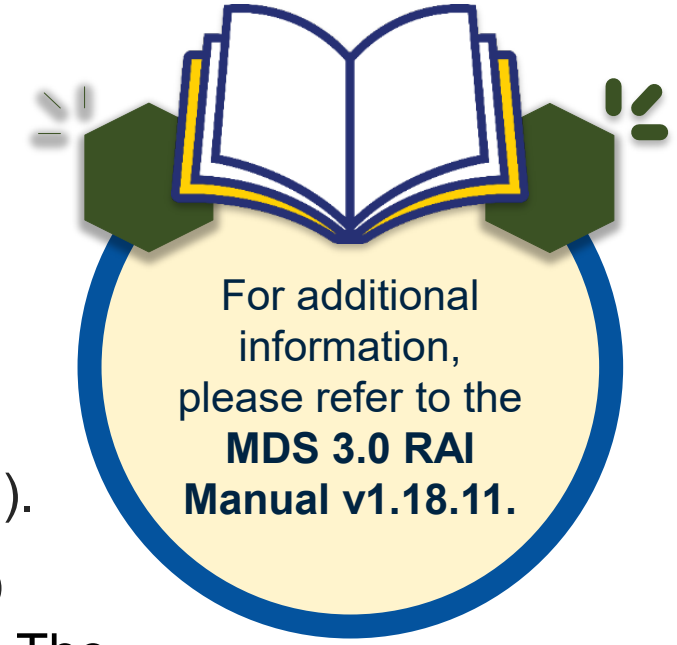
# A2000. Discharge Date


- 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. In summary:
  - 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.



# A2105. Discharge Status

This data element was aligned across some PAC settings and renumbered.

OLD

**A2100. Discharge Status**

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric ho**
05. **Inpatient reha**
06. **ID/DD facility**
07. **Hospice**
08. **Deceased**
09. **Long Term Ca**
99. **Other**

NEW

**A2105. Discharge Status**

Complete only if A0310F = 10, 11, or 12

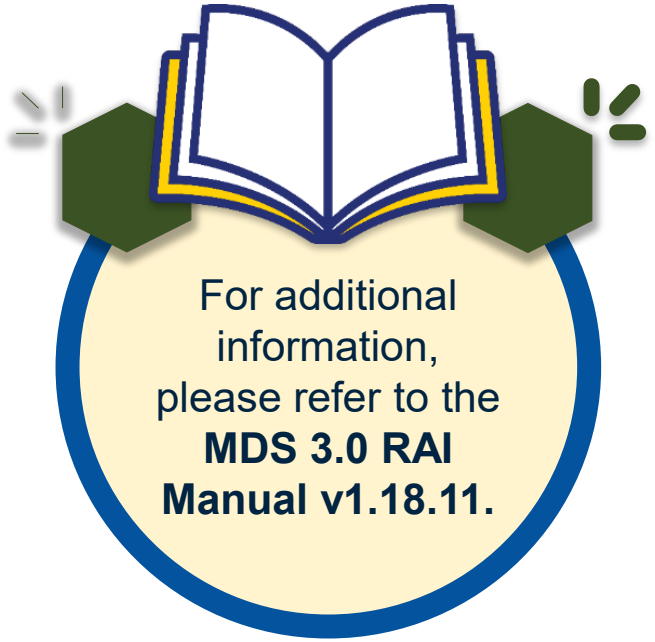
Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

# A2105. Discharge Status – Item Rationale

**Item Rationale:** This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. See the Glossary and Common Acronyms in Appendix A for additional descriptions of these settings.

- Coding Instructions were updated for each response option and are defined in the same way as those in A1805. Entered From.



# A2400. Medicare Stay – Coding Tips

NEW

CODING TIPS

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

**A2400. Medicare Stay**

Complete only if A0310G1 = 0

Enter Code ☐

**A. Has the resident had a Medicare-covered st**
0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of

**B. Start date of most recent Medicare stay:**
☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

**C. End date of most recent Medicare stay** - Ent
☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

**A0310. Type of Assessment - Continued**

Enter Code ☐

**G. Type of discharge** - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

Enter Code ☐

**G1. Is this a SNF Part A Interrupted Stay?**
0. **No**
1. **Yes**

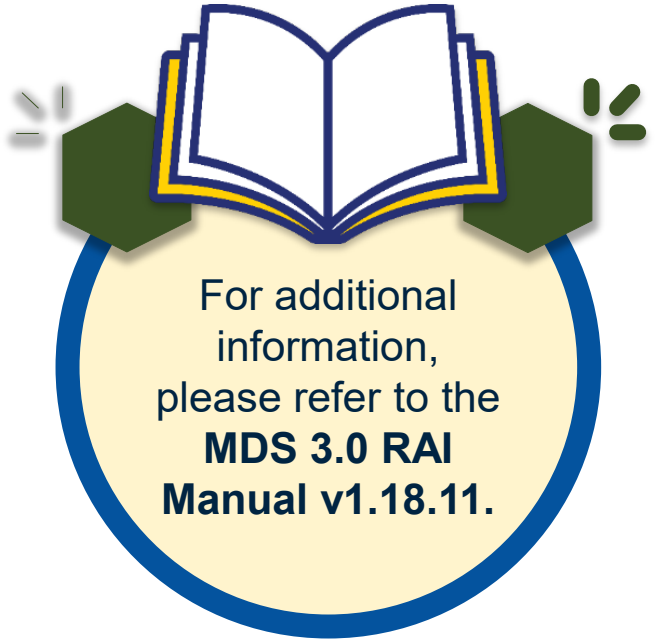
Enter Code ☐

**H. Is this a SNF Part A PPS Discharge Assessment?**
0. **No**
1. **Yes**

# Section B:
# Hearing, Speech, and Vision

# 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 slight changes were made to guidance to enhance clarity, and new examples were added for both data elements.



# Section F: Preferences for Customary Routines and Activities

# F0300. Should Interview for Daily and Activity Preferences be Conducted?


Steps for Assessment:

2. 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.

# F0300. Should Interview for Daily and Activity Preferences be Conducted? (cont.)

REVISED

3. 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.

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



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# Section H: Bowel and Bladder

# H0100. Appliances – Coding Tips

CODING TIPS

Do not include one-time catheterizations for urine specimen collection or other diagnostic exams (e.g., to measure post-void residual) during look-back period as intermittent catheterization.




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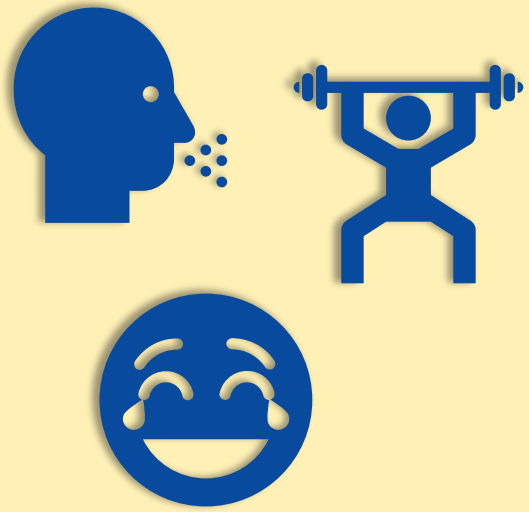
# H0300. Urinary Continence – Definition

NEW

## 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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# Section I: Active Diagnoses

# I0020. Indicate the Resident's 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

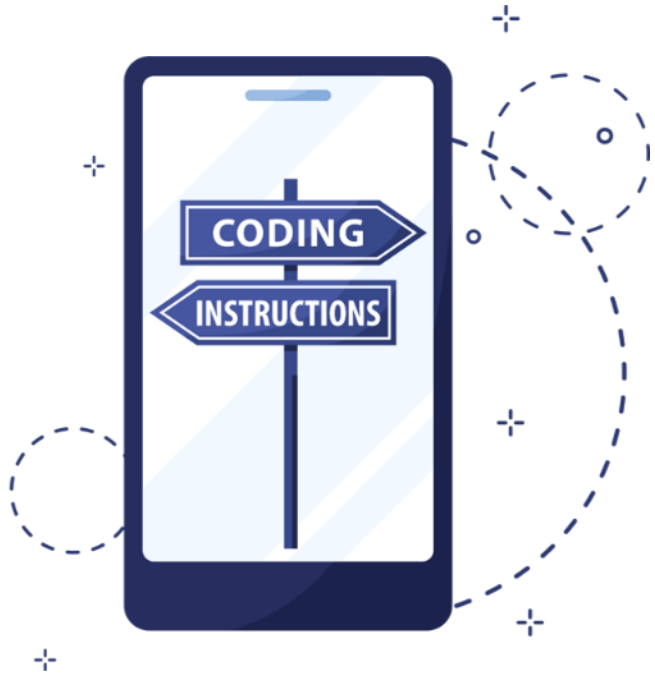
01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**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

**I0020B. ICD Code**

# I0020B. ICD Code – Coding Instructions

When an acute condition represents the primary reason for the resident's SNF stay, it can be coded in I0020B.

However, it is more common that a resident presents to the SNF for care related to an aftereffect of a disease, condition, or injury. Therefore, subsequent encounter or sequelae codes should be used.



# Section M: Skin Conditions

# M0210. Unhealed Pressure Ulcers/Injuries

NEW

CODING TIPS

Skin changes at the 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.



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# M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage


Step 1: Determine Deepest Anatomical Stage instructions updated:

- 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.

3. 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.

# M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (cont.)


5. …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.

6. 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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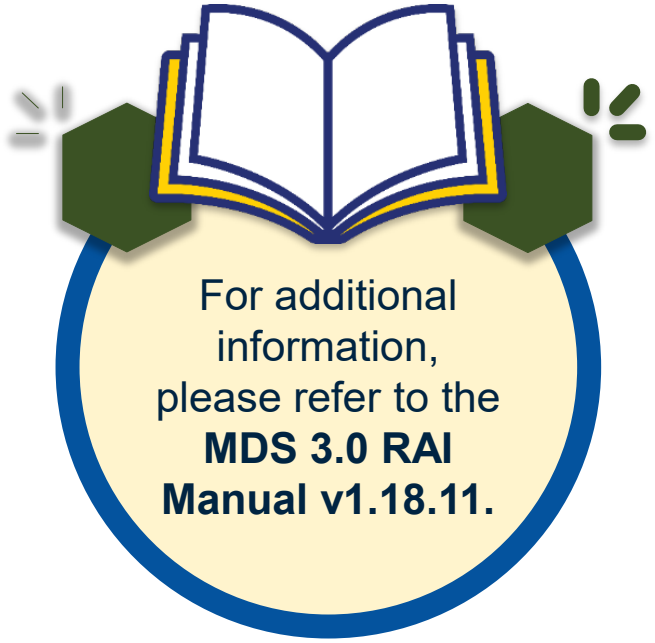
# Step 3: Determine Present on Admission


10. 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.



# Section X: Correction Request

# Section X: Correction Request


- 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.

# Summary

- The MDS contains data elements that were standardized across PAC settings.
- Other standardized data elements were added to the MDS.
- Several updates were made to the RAI Manual guidance based on:
  - Changes made to the MDS.
  - Need for clarification.

# Submitting Questions

If you have questions about this presentation, please submit them to PACTraining@EconometricaInc.com by June 2, 2023.

Select questions will be answered in Q&A sessions offered during the June 2023 virtual live event.