SKILLED NURSING FACILITY QUALITY REPORTING PROGRAM PROVIDER TRAINING

Participant Questions from the

SKILLED NURSING FACILITY MDS 3.0 RAI v1.18.11 GUIDANCE TRAINING PROGRAM

On June 21, 2023

Current as of August 2023

Acronym List

Acronym	Definition
ADL	Activities of Daily Living
ARD	Assessment Reference Date
BIMS	Brief Interview for Mental Status
BiPAP	Bilevel Positive Airway Pressure
CAA	Care Area Assessment
CAH	Critical Access Hospital
CAT	Care Area Trigger
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure
DTI	Deep Tissue Injury
EHR	Electronic Health Record
EMR	Electronic Medical Record
FDA	Food and Drug Administration
FiO2	Fraction of Inspired Oxygen
HIE	Health Information Exchange
IDT	Interdisciplinary Team
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IV	Intravenous
IVF	Intravenous Fluids
KTU	Kennedy Terminal Ulcers
LTC	Long-Term Care
LTCH	Long-Term Care Hospital
MDS	Minimum Data Set

Acronym	Definition
NF	Nursing Facility
NH	Nursing Home
NHSN	National Healthcare Safety Network
NPE	Nursing Home Part A PPS Discharge
O2	Oxygen
OBRA	Omnibus Budget Reconciliation Act of 1987
OT	Occupational Therapy/Therapist
PHQ-2 to 9©	Resident Mood Interview
PHQ-9-OV©	Staff Assessment of Resident Mood
PICC	Peripherally Inserted Central Catheter
PPS	Prospective Payment System
PRN	Pro re nata
PT	Physical Therapy/Therapist
QRP	Quality Reporting Program
RAI	Resident Assessment Instrument
RN	Registered Nurse
RT	Respiratory Therapy
SB	Swing Bed
SCALE	Skin Changes at the End of Life
SCPA	Significant Correction to Prior Comprehensive Assessment
SCSA	Significant Change of Status Assessment
SDOH	Social Determinants of Health
SLP	Speech Language Pathologist
SNF	Skilled Nursing Facility
SOM	State Operations Manual
TPN	Total Parenteral Nutrition
UTI	Urinary Tract Infection
WC	Wheelchair

Table of Contents

General Questions

#	Topic	Question	Response
1	Swing Bed Providers	Are there any specific training links or programs available for non-critical access hospital Swing Bed (SB) providers?	Please refer to the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Training page to find a library of available training materials: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/skilled-nursing-facility-quality-reporting-program/snf-quality-reporting-program-training.
2	Resident Interviews	If a resident is not new and we already have this information, do we need to do another interview starting in October?	Some of the new data elements in the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) 3.0 v1.18.11 User's Manual are now resident interviews, for example, the new Ethnicity and Race data elements found in Section A. Regarding completion of assessments, these are to be based on the appropriate schedule of assessments (i.e., Prospective Payment System [PPS] and/or Omnibus Budget Reconciliation Act of 1987 [OBRA]) for the resident. If a resident interview was conducted on a prior assessment, the next scheduled assessment would need to be reviewed to determine if the resident interview is active on that assessment. If it is, then the facility is required to complete the resident interview as per the guidance in the RAI Manual for the interview being completed for that specific assessment. The facility is not required to repeat resident interviews in October unless a new assessment is required per the resident's assessment schedule that includes the resident interviews. If this is the case, and the assessment is to be completed before October 1, 2023, the facility would use v1.17.2 of the MDS Item Sets, but after October 1, 2023, the facility would use v1.18.11 of the MDS Item Sets.
3	Resident Interviews	Are the interviews in sections C, D, F, and J required to be completed the day before or on the Assessment Reference Date (ARD)?	These interviews should be conducted during the look-back period of the ARD. Please refer to the Coding Tips and Steps for Assessment in the MDS RAI 3.0 v1.18.11 User's Manual for each specific section for more information.
4	CAA Worksheet Terminology	The Appendix C Care Area Assessment (CAA) worksheets updated the name of the #5 care area to "Functional Abilities (Self-Care and Mobility). However, Chapter 4 and Section V continue to refer to the #5 care area as "Activities of Daily Living (ADL) Functional/Rehabilitation Potential."	The Centers for Medicare and Medicaid (CMS) has aligned the CAA worksheet with the other referenced areas to state ADL Functional/Rehabilitation Potential.

#	Topic	Question	Response
5	Social Determinants of Health (SDOH) Data Elements	Do SDOH data elements only apply to Medicare 5-Day and Part A PPS Discharge?	SDOH health data elements are collected on other item sets/assessments (e.g., Nursing Home Comprehensive and Quarterly). Please see Appendix F: Item Matrix in the MDS RAI 3.0 v1.18.11 User's Manual, which shows the item sets on which each data element is active. Also please review the sections associated with the SDOH data elements in the MDS RAI 3.0 v1.18.11 User's Manual for additional information.
6	Standardized Patient Assessment Data Elements	Are all standardized patient assessment data elements social determinants of health questions?	No, not all standardized patient assessment data elements fall under the domain of social determinants of health; they fall into a variety of different domains. For more information on standardized patient assessment data elements, please go to: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/post-acute-care-quality-initiatives/impact-act-of-2014/-impact-act-standardized-patient-assessment-data-elements.

Section A

#	Topic	Question	Response
7	Nursing Home Definition for A1805 & A2105	Please clarify the definition of Nursing Home. The definition of Nursing Facility (NF) in Appendix A references providing skilled services, which is confusing to the term "skilled nursing facility." Clarify how to select entry and discharge locations for A1805 and A2105: **Nursing Facility** • A facility that is primarily engaged in providing skilled nursing care and related services to individuals who require medical or nursing care or rehabilitation 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. **Skilled Nursing Facility** • A facility that is primarily engaged in providing skilled nursing care and related services to individuals who require medical or nursing care or rehabilitation services of injured, disabled, or sick persons. If a resident enters from a SNF but was a custodial resident in the long-term care section of this SNF, would A1805. Entered From be coded as 02, Nursing Home, or 03, Skilled Nursing Facility?	For A1805. Entered From, Code 02, Nursing Home (long-term care facility), is indicated 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. Code 03, Skilled Nursing Facility (SNF, swing bed), is indicated 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. When a dually certified nursing facility serves as the setting in which the resident received care immediately prior to entering the current facility, the assessor should code A1805. Entered From, based on the provision of services the resident received immediately prior to discharge. If those services were skilled nursing services, skilled rehabilitative services, and/or other related health services, regardless of payor source, the assessor should code as 03, Skilled Nursing Facility. If those services were custodial in nature (i.e., medical and non-medical care to address a chronic illness or disability), the assessor should code 02, Nursing Home. Similarly, for A2105. Discharge Status, Code 02, Nursing Home (long-term care facility) is indicated if the resident is being discharged to an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability. Code 03, Skilled Nursing Facility (SNF, swing bed), is indicated if the resident is being discharged to 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 discharged to a SNF swing bed in a swing bed hospital. If the resident is being discharged to a dually certified nursing facility, the assessor should code A2105. Discharge Status, based on the provision of

#	Topic	Question	Response
			services the resident will receive upon discharge. If those services will be skilled nursing services, skilled rehabilitative services, and/or other related health services, regardless of payor source, the assessor should code 03, Skilled Nursing Facility. If those services will be custodial in nature (i.e., medical and non-medical care to address a chronic illness or disability), the assessor should code 02, Nursing Home.
8	Setting Prior to Admission/Entry or Reentry	For A1805, would you code 02 (NH) for a Medicaid stay and code 03 (SNF/SB) for a Medicare stay?	Enter the two-digit code that best describes the setting the resident was in immediately preceding this admission/entry or reentry. Per the definitions provided in A1805, the assessor would use 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. The assessor would use Code 03, Skilled Nursing Facility, 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.
9	Nursing Home vs. Skilled Nursing Facility	Can you please clarify the difference between 02, Nursing Home and 03, Skilled Nursing Facility for Section A1805 and A2121? Some facilities are licensed as both nursing homes and skilled nursing facilities. Is it based on license type? Or is it based on services provided? For example, if the person was receiving skilled services it would be 03, but if they were receiving custodial care/non-skilled services it would be 02?	When a dually certified nursing facility serves as the setting in which the resident received care immediately prior to entering the current facility, the assessor should code A1805. Entered From, based on the provision of services the resident received immediately prior to discharge. If those services were skilled nursing services, skilled rehabilitative services, and/or other related health services, regardless of payor source, the assessor should code as 03, Skilled Nursing Facility. If those services received immediately prior to discharge were custodial in nature (i.e., medical and non-medical care to address a chronic illness or disability), the assessor should code as 02, Nursing Home.
10	A1805 & A2105	In Washington, as with other states, there are now stand-alone “Memory Care” facilities – some of which are physician supervised, others are not. There is usually some form of skilled care available. For A1805 and A2105, can you please clarify in the Manual if these are: (01) Home/Community (e.g., assisted living) (07) Inpatient Psychiatric Facility (08) Intermediate Care Facility (12) Home under care of organized home health service organization?	To answer these data elements, please consult with your local State survey agency to determine how the memory care facilities in question are licensed.

#	Topic	Question	Response
11	Section A Resident Interviews	Is Section A now considered an interview section and must be signed off by ARD?	According to Chapter 3, 3.3 Coding Conventions, in the MDS RAI 3.0 v1.18.11 User's Manual, the standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated. The Guidance in Chapter 3, 3.1 Using This Chapter, notes that the symbol  is displayed in all sections/items that require a resident interview. In Section A, these items include A1005. Ethnicity, A1010. Race, A1110. Language, and A1250. Transportation. Resident interview items must be conducted during the look-back period.
12	ARD and Resident Interviews	Do we complete the new interview/resident self-report items such as Health Literacy, Transportation, and Social Isolation before or after the ARD?	The ARD refers to the specific endpoint for the observation (or "look-back") periods in the MDS assessment process. MDS 3.0 items have a 7-day look-back period unless otherwise noted. Therefore, providers are to conduct the interviews during the 7-day look-back period based on the ARD.
13	A1005. Ethnicity	How do you code ethnicity if the resident provides two different answers? For example, the resident answered A1005 as B, Yes, Mexican, Mexican American, Chicano/a on initial admission, was transferred to the hospital, but upon readmission to the SNF answered, "I don't considered myself Hispanic"?	If the resident provides a response, even if it differs from a previous response, check the box(es) indicating the ethnic category or categories identified by the resident.
14	A1005. Ethnicity and A1010. Race Data Collection	For data elements A1005. Ethnicity and A1010. Race, our admission department collects this data as part of our pre-admission process from the hospital. Can we use that information to code these data elements, or do they need to be assessed after the resident is admitted?	A1005. Ethnicity and A1010. Race are self-reported data elements, and the questions for each should be asked of the resident after they are admitted to the facility, during the appropriate assessment period. Facility medical record documentation can be used as the data source for these data elements only if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response.
15	A1005. Ethnicity and A1010. Race	Once we've interviewed the resident for ethnicity and race on their first assessment, do we have to ask them on every assessment?	Yes, the assessor must follow the Steps for Assessment for A1005. Ethnicity and A1010. Race on each assessment, starting with asking the resident.

#	Topic	Question	Response
16	Coding Data Elements in Section A	Do MDS Items A1005. Ethnicity, A1010. Race, A1110. Language, and A1200. Marital Status, require the resident to be asked the questions again during the 7-day look-back period on all subsequent assessments after the initial 5-Day and/or Admission assessment? Or can responses collected at the start of the stay or new admission be carried forward to subsequent assessments? Are these resident responses able to be coded directly on the MDS, as allowed with scripted interviews, without additional supporting documentation in the medical record?	The assessor should follow the steps for assessment for these items for each assessment on which the items appear. The assessor can code the resident's response directly on the assessment as with other interview items.
17	A1110. Language	Can you clarify for A1110B what we are supposed to code if a resident states they don't need an interpreter, but the family says the resident does need an interpreter?	If the resident responds that they do not need an interpreter, their response should be the primary source for coding this data element. If it becomes clear that the resident is unable to understand what is being communicated to them, or they cannot communicate their needs, the facility should reassess and ask a family member, significant other, or guardian/legally authorized representative.
18	A1250. Transportation	Is there a look-back period for the transportation question?	The guidance in Chapter 3, 3.3 Coding Conventions, notes that the standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated. Some data elements may ask the resident to consider a longer timeframe at the time the question is asked. In the case of A1250, the assessor asks the resident at the time of the assessment (which must be conducted during the look-back period) to consider whether if over the past 6 months to a year they have had transportation issues. Depending on the resident's response, the assessor would choose the appropriate response code for A1250.
19	A1250. Transportation Timeframe	New MDS item, A1250. Transportation, asks the base question: "In the past six months to a year, has lack of transportation kept you from…" The timeframe mentioned in this question may lead to confusion and inaccuracy. Does this question intend to include the past six months and up to the last year? If the past six months are included, does it also include time while in the facility?	The assessor should follow the steps for assessment for item A1250 and ask the resident, "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?" and "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?" The assessor then codes the item based on the resident's interpretation of the question. This question may include time in the facility or in another facility, as well as in a home or community-based setting.

#	Topic	Question	Response
20	Therapy Start Date	The draft manual provides the definition of "Therapy start date" as: Therapy Start Date—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption, in cases where the resident discontinued and then resumed therapy." This instruction specifically states that the look-back is to since the most recent entry at A1600; however, coding tips contradict the definition in cases of interrupted stays. Would CMS consider redefining the definition of "therapy start date" to reflect the exception with interrupted stays?	Taken together, the additional coding tips in the MDS RAI 3.0 v1.18.11 User's Manual clearly indicate that the interrupted stay is an exception to what is entered on the MDS for the therapy start date. The CMS team does not believe that additional changes are necessary.
21	A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge	Does transmission of the reconciled medication list to a primary care provider count?	No, a primary care provider is not considered a subsequent provider for coding A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge. Rather, a subsequent provider is based on the discharge locations in A2105 and defined as any of the following: 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.

#	Topic	Question	Response
22	A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge	Can A2121 be coded yes if the medication list was given to the resident/family at discharge to bring to the follow up clinic appointment?	The intent of A2121. Provision of Current Reconciled Medication List to Subsequent Provider is to determine whether, at the time of discharge, the resident's reconciled medication list was provided to a subsequent provider. For the purposes of coding this data element, a subsequent provider is based on the discharge locations responses 02 through 12 in A2105. Discharge Status. Because your question did not state whether the resident was discharged home without home care services or with home care services, we are providing a response that includes how to code A2121 considering both discharge scenarios: If, in your scenario, the resident is discharged home and A2105 is coded as 01, Home/Community, or Code 99, Not listed, then A2121 would be skipped. A2123. Provision of Current Reconciled Medication List to Resident at Discharge would be coded as 1, Yes, to indicate that your facility provided the resident's medication list to the resident, family member, guardian/legally authorized representative, and/or caregiver. If, in your scenario, the resident is discharged home with home care services and A2105 is coded as 12, Home under care of organized home health service organization, A2121 would be coded as 0, No, because the facility did not provide the reconciled medication list to the home health service organization, and you would skip to the next active data element. While the resident may receive care from other providers after discharge from your facility, such as primary care providers, other outpatient providers, and residential treatment centers, these locations are not considered to be a subsequent provider for the purpose of coding this item.
23	A2121. Provision of Reconciled Medication List to Subsequent Provider at Discharge	If a resident is discharged to home with home health services and a reconciled medication list is only given to the resident at discharge, would this be considered as provided to the subsequent provider for A2121. Provision of Reconciled Medication List to Subsequent Provider at Discharge?	A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge identifies if, at the time of discharge, the facility provided the resident's current reconciled medication list to a subsequent provider as listed in A2105. Discharge Status. In this scenario, if the facility did not provide a reconciled medication list to the home health agency, A2121 would be coded as 0, No. The rationale is that the resident was discharged to a subsequent "provider" defined in A2105. Discharge Destination (12, Home under care of organized home health service organization), and the SNF did not provide the reconciled medication list to the subsequent provider (the home health agency).

#	Topic	Question	Response
24	A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider	Will we need proof in the chart if paper-based is used for A2122?	Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual, states that the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including Route of Current Reconciled Medication List Transmission to Subsequent Provider, according to their facility policy and procedure and in compliance with any Federal and State requirements.
25	A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider	Please explain the difference between Electronic Health Record (EHR) and Health Information Exchange (HIE). In the practice scenario, I thought A2122 was both.	An EHR is an electronic health record that is maintained by the provider over time. An HIE is a health information exchange through which resident information can be securely exchanged between provider(s) and/or resident(s). Please see the following links for further information: EHR: https://www.healthit.gov/faq/what-electronic-health-record-ehr. HIE: https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie.
26	A2123. Provision of Current Reconciled Medication List to Resident at Discharge	Item A2123 states "Complete only if A0310H=1 and A2105=01, 99." But if the resident is discharged home, then A0310H would be 2, Yes, not 1, No, because it would be a PPS discharge assessment. Please advise. Is this a typo in the data set?	A0310H. Is this a Part A PPS Discharge Assessment? response choices only include 0, No and 1, Yes. There is no response choice of "2" for A0310H.

#	Topic	Question	Response
27	A2122 & A2124 Routes of Transmission of Health Care Information	For routes of transmission of health care information, does this need to be documented in the medical record?	This information may or may not be documented in the medical record; however, it is good practice to establish the route of transmission with each subsequent provider depending on how they are able to receive information from your facility. Please see Coding Tips for A2122 and A2124 in the MDS RAI 3.0 v1.18.11 User's Manual for more guidance. Also, note that while CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS.
28	A2124. Route of Current Reconciled Medication List Transmission to Resident	I have a question regarding A2124. Route of Current Reconciled Medication List Transmission to Resident. In this item the EHR, Electronic Medical Record (EMR), and HIE were included. But usually, the resident or caregiver does not use these routes. Were these added in this item because of other settings such as Assisted Living Facility?	The intent of adding the route of current reconciled medication list transmission to subsequent providers (A2122) and residents/caregivers (A2124) is to monitor how medication lists are transmitted on discharge. The routes listed are common ways in which providers can exchange or provide information to residents and other health care providers. A HIE is a portal where both health care providers and residents can access and share vital resident information. While an HIE may not be as common as paper, for example, it is a route through which this information can be exchanged and accessed regardless of care setting. An EHR is another way in which vital resident information can be transmitted or provided to other health care providers and residents/caregivers. This can occur through a common EHR system (e.g., in an integrated health system) or a resident portal where residents/caregivers can request and be given access to view and/or download the information. Again, this is a route that can be used regardless of care setting.

Section B

#	Topic	Question	Response
29	B1300. Health Literacy	What if health literacy is due to a language barrier?	If a resident has a language barrier, this is a significant barrier to health literacy. In the facility, the resident should be assessed for the need for an interpreter. And if the resident needs an interpreter, the facility must ensure that an interpreter is available. 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.

Section C

#	Topic	Question	Response
30	C0200–C0500 Brief Interview for Mental Status (BIMS)	I noticed there was a change in the instructions for C0200–C0500: Brief Interview for Mental Status that states that the administration of the BIMS in writing should be limited to only a circumstance where the resident's primary method of communication is in written format. I have had numerous residents with expressive aphasia from a stroke, and have found that some of them are able to complete the BIMS, usually by parroting the three words after hearing them, followed by pointing to multiple choice answers written on cue cards. This has helped us to understand that while not able to communicate well, these residents are frequently still oriented and understand the situation around them more than others may realize. Often these clients' method of communication is by nodding their heads yes or no, and they are not able to write. So given that the resident uses multiple methods of communication (not primarily written), would they be excluded from having the BIMS administered in writing, even if it would promote their voice?	The determination of a resident's primary method of communication should be based on clinical judgment. As noted in the Steps for Assessment (Step 1), the assessor should interact with the resident using their preferred language (see A1110). Be sure they can hear you and/or have access to their preferred method for communication. If the resident needs or requires an interpreter, complete the interview with an interpreter. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. In addition, the guidance in Appendix D: Interviewing to Increase Resident Voice states: “Say and show the item responses. • It is helpful to many older adults to both hear and read the response options. • As you verbally review the response options, show the resident the items written in large, clear print on a piece of paper or card. • Residents may respond to questions verbally, by pointing to their answers on the visual aid or by writing out their answers.”

Section D

#	Topic	Question	Response
31	D0150. Resident Mood Interview Look-Back Period	D0100 and D0150 removed the instruction to complete the interview "preferably the day of or the day before the ARD" but states the interview should be completed during the look-back period. Can CMS clarify if the look-back period for the PHQ-2 to 9© mood interview is 7 days or 14 days?	The Resident Mood Interview (PHQ-2 to 9©) asks the resident to answer questions about their mood and feelings over the past 2 weeks. This interview is conducted during the look-back period of the Assessment Reference Date (ARD). As noted in Chapter 3, Section 3.3 Coding Conventions, the standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated.
32	D0150. Resident Mood Interview Look-Back Period	For the Resident Mood Interview (PHQ-2 to 9©), do we include the period prior to admission? For example, if the resident has been in the facility for 5 days, would you include the days before admission?	Yes, as the MDS RAI 3.0 v1.18.11 User's Manual guides in the Steps for Assessment, for each of the questions read the item as written. The Resident Mood Interview (PHQ-2 to 9©) asks the resident to answer questions about their mood and feelings over the past 2 weeks. This interview is conducted during the look-back period of the ARD. The standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated.
33	D0150. Resident Mood Interview Cardinal Symptoms	What is the rationale for limiting the PHQ-9© to PHQ-2©?	The Resident Mood Interview (PHQ-2 to 9©) is a validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The PHQ-2© addresses the two cardinal symptoms of depression (depressed mood and inability to feel pleasure), and during testing it performed well as a screening tool to identify depression, to assess depression severity, and to monitor a resident's mood over time. The embedded skip pattern is designed to reduce the length of the interview assessment for residents who fail to report the cardinal symptoms of depression. The design of the PHQ-2 to 9© reduces the burden that would be associated with the full PHQ-9©.

#	Topic	Question	Response
34	D0150. Resident Mood Interview	Why do we have to stop the Resident Mood Interview (PHQ-2 to 9©) after only 2 questions? Many residents express all the symptoms of depression but answer "no" to the question about feeling down, depressed, or hopeless (D0150B).	The PHQ-2© addresses the two cardinal symptoms of depression (depressed mood and inability to feel pleasure) and during testing it performed well as a screening tool to identify depression, to assess depression severity, and to monitor a resident's mood over time. As stated in the Steps for Assessment for this item, if both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, end the PHQ interview; otherwise continue. It is important to note that coding the presence of clinical signs and symptoms of depressed mood does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis based on these findings; they simply record the presence or absence of specific clinical signs and symptoms of depressed mood. Facility staff should recognize these signs and symptoms and consider them when developing the resident's individualized care plan. When conducting the Resident Mood Interview (PHQ-2 to 9©), the assessor should read each item as it is written. Do not provide definitions, because the meaning must be based on the resident's interpretation. Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician. As noted in the Interviewing Tips and Techniques for this item, the assessor should repeat a question if the assessor thinks it has been misunderstood or misinterpreted. Noncommittal responses such as "not really" should be explored. Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered them, even if it was only some of the time.
35	D0150. Resident Mood Interview Coding Sources	For D0150, can you use hospital records for the look-back period? For example, if the resident was experiencing depression and fatigue for 2-3 days in the hospital, but once they are admitted to the SNF they state they are not experiencing these feelings anymore?	The responses to the D0150. Resident Mood Interview (PHQ-2 to 9©) are based on resident interview only. The assessor should not use record review, staff interview, or other sources to inform coding.

#	Topic	Question	Response
36	D0150. Resident Mood Interview	Consider this coding example: The resident provides a non-sensical response to D0150A1 and you code it as a 9 and leave D0150A2 blank. But then the resident responds to D0150B1 as a yes and states that the symptoms bothered them 12-14 days. The RAI manual refers to "both" in the guidance, so would you proceed with the interview?	The Steps for Assessment state that you should determine whether to ask the remaining seven questions (D0150C to D0150I) of the Resident Mood Interview (PHQ-2 to 9©). Whether or not further evaluation of a resident's mood is needed depends on the resident's responses to the first two questions (D0150A and D0150B) of the Resident Mood Interview. If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, end the PHQ interview; otherwise continue. For all other scenarios, proceed to ask the remaining seven questions (D0150C to D0150I of the PHQ-9©) and complete D0160. Total Severity Score. Based on your coding example, this would be considered as an "other coding scenario" (as noted in the guidance above). Therefore, you would proceed to ask the remaining seven questions.
37	D0150. Resident Mood Interview	How do you code D0150 if the resident does not respond with number of days or even with "several days"/"over half," but rather states "sometimes" and does not clarify further?	As noted in the guidance, if the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions (unfolding). A cue card with the response choices clearly written in large print might also help the resident comprehend the response choices. For noncommittal responses, you can also probe by asking neutral or nondirective questions. Repeat a question if you think that it has been misunderstood or misinterpreted. Please refer to the Interviewing Tips and Techniques for the Resident Mood Interview in Chapter 3 of the MDS RAI 3.0 v1.18.11 User's Manual for additional information on how to conduct this interview.
38	D0150. Resident Mood Interview	The speaker stated a dash was not an option for Column 2. What would be coded if the resident did not answer the frequency item if a dash and a 99 are not allowed for coding Column 2, Symptom Frequency?	Coding for Column 1, Symptom Presence, will inform the coding of Column 2, Symptom Frequency, in certain circumstances. If the resident was unable or chose not to complete the assessment or responded nonsensically, use Code 9, No response for Column 1, Symptom Presence, and leave Column 2, Symptom Frequency, blank. In the scenario you provided, the resident did not complete the assessment as they did not answer the Symptom Frequency question. Therefore, you would use Code 9, No response, for Column 1, Symptom Presence, and leave Column 2, Symptom Frequency, blank.
39	D0150. Resident Mood Interview	When coding D0150. Resident Mood Interview, if A2 is 0 and B2 is 1, would you end the interview, or do both these items have to be 1 or 0 in order to end the interview?	If both D0150A2 and D0150B2 are coded 0 or 1, then end the PHQ-2© and enter the total score from D0150A2 and D0150B2 in D0160. Total Severity Score.

#	Topic	Question	Response
40	BIMS vs. the Resident Mood Interview	If the BIMS score is low, is the PHQ-2 to 9© to be completed?	Coding of the BIMS should not influence whether the resident has the opportunity to participate in the PHQ-2 to 9©. Most residents who are capable of communicating can answer questions about how they feel. Obtaining information about mood directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying a mood disorder. Per the Steps for Assessment for this item, interview any resident when D0100. Should Resident Mood Interview Be Conducted? = 1, Yes.
41	Use of Dash	When can I use a dash for coding D0150A?	Enter a dash in Column 1, Symptom Presence, if the symptom presence was not assessed, and leave Column 2, Symptom Frequency, blank.
42	Using a Dash for D0150 Column 2, Symptom Frequency	I see that a dash is a valid response for D0150 Column 1, Symptom Presence. Can a dash be used for D0150 Column 2, Symptom Frequency?	A dash is no longer a valid response for Symptom Frequency.
43	PHQ-2 to 9© Coding Column 2, Symptom Frequency	Can you explain the reasons why Column 2, Symptom Frequency would be left blank? If the items in Column 2 are left blank, does this automatically mean that we do not complete the rest of the PHQ-2 to 9©?	There are a couple of reasons why the coding for Column 2, Symptom Frequency, would be left blank. If coding in Column 1, Symptom Presence, is a 9, No response, or coding in Column 1, Symptom Presence, is a dash, then Column 2, Symptom Frequency, would be left blank. You would end the PHQ-2© and not complete the rest of the PHQ-9© if both D0150A1 and D0150B1 are coded as 9. Another situation in which the remaining seven questions would not be answered is if both D0150A2 and D0150B2 (Symptom Frequency) are coded as a 0 or 1. For all other scenarios, proceed to ask the remaining seven questions (D0150C to D0150I of the PHQ-9©) and complete D0160. Total Severity Score.
44	PHQ-2 to 9© Interview	Consider this scenario. The resident answers D0150A as 1, Yes, and reports that the symptoms bothered them on one day over the past two weeks, so you use Code 0, Never or 1 day for Column 2, Symptom Frequency. Then when asked about D0150B, the resident states that they do not want to answer that question and declines. Therefore, you code Symptom Presence as a 9 and leave Symptom Frequency blank for D0150B. Would you continue with the PHQ-9© interview?	Since both D0150A1 and D0150B1 were not coded 9 and both D0150A2 and D0150B2 were not coded 0 or 1, you would proceed with asking the remaining seven questions (D0150C to D0150I of the PHQ-9©) and complete D0160. Total Severity Score, per the guidance in Appendix E.

#	Topic	Question	Response
45	Stopping the Resident Mood Interview	Can you clarify whether we stop the Resident Mood Interview (PHQ-2 to 9©) if both D0150A1 and D0150B1 are coded 1? Why?	Whether or not further evaluation of a resident's mood is needed depends on the resident's responses to the first two questions (D0150A and D0150B) of the Resident Mood Interview. If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, end the PHQ interview; otherwise continue. The reason that the interview is stopped at this point in these circumstances is that the Resident Mood Interview (PHQ-2 to 9©) is a validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The PHQ-2© addresses the two cardinal symptoms of depression (depressed mood and inability to feel pleasure) and during testing it performed well as a screening tool to identify depression, to assess depression severity and to monitor a resident's mood over time. The embedded skip pattern is designed to reduce the length of the interview assessment for residents who fail to report the cardinal symptoms of depression. The design of the PHQ-2 to 9© reduces the burden that would be associated with the full PHQ-9©.
46	D0160. Total Severity Score	How would you code D0160. Total Severity Score using this example: A resident is participating in the Resident Mood Interview providing responses to questions and identifying symptom frequencies for D0150A through D0150E. However, after providing an answer for D0150E. Poor Appetite or overeating, despite your encouragement they decline to answer any more questions. You code the symptom presence for D0150F through D0150I as a 9, No response and the Symptom Frequency for the items D0150F through D0150I is left blank.	In the scenario you provided, the Resident Mood Interview had four blank responses in Column 2 (D0150F2 through D0150I2). These four blank responses are considered missing items for Column 2. The guidance in Appendix E states that if the number of missing items in Column 2 is equal to three or more, then item D0160 must equal 99.
47	D0160. Total Severity Score	Would you explain how blank answers for the last seven questions in PHQ-2 to 9© could result in a higher Total Severity Score for D0160?	D0160. Total Severity Score is obtained by adding the numeric scores across all frequency items in D0150. Resident Mood Interview, Column 2. The maximum resident score is 27 (9 questions X response option 3) if all questions were answered. If symptom frequency in items D0150A2 through D0150I2 is blank for 3 or more items, the interview is deemed NOT complete. Total Severity Score should be coded as "99," and the Staff Assessment of Mood should be conducted, unless the assessment being completed is a stand-alone Part A PPS Discharge; if that is the case, then skip to D0700. Social Isolation.

#	Topic	Question	Response
48	D0500. Staff Assessment of Resident Mood Look-Back Period	D0500. Staff Assessment of Resident Mood removed the 14-day look-back and added instruction of "Conduct the interviews during the 7-day look-back period based on the ARD." Please clarify if the staff interviews at D0500 must be conducted at any time during the 7-day look-back window, but cannot be conducted after the ARD?	The instructions for D0500 state to conduct D0500. Staff Assessment of Resident Mood (PHQ-9-OV©) if D0150. Resident Mood Interview is not completed. Under Steps for Assessment, instruction is provided to conduct the interviews during the 7-day look-back period based on the ARD. This assessment may be conducted at any time during the 7-day look-back; however, it cannot be completed after the ARD.
49	D0500. Staff Assessment of Resident Mood	If both D0150 A1 and B1 were coded 9, No Response, would you do a Staff Assessment of Resident Mood (PHQ-9-OV©)?	Yes, if both D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 blank, then end the PHQ-2©, and leave D0160. Total Severity Score blank. The assessor then completes D0500. Staff Assessment of Resident Mood (PHQ-9-OV©).
50	D0500. Staff Assessment of Resident Mood	Is there a staff interview for assessing resident mood?	Yes, D0500 is the Staff Assessment of Resident Mood (PHQ-9-OV©). The PHQ-2 to 9© Resident Mood Interview is preferred as it improves the detection of a possible mood disorder. However, a small percentage of residents are unable or unwilling to complete the PHQ-2 to 9© Resident Mood Interview. Therefore, staff should complete the PHQ-9-OV© Staff Assessment of Mood in these instances so that any behaviors, signs, or symptoms of mood distress are identified.
51	D0700. Social Isolation	For D0700. Social Isolation, will there be additional guidance to help clinicians determine the difference between response options "sometimes" and "often"? Will the definitions for "sometimes" and "often" be provided?	D0700. Social Isolation is a resident self-report data element, and the interpretation of the response choices is up to the resident to determine for themselves. The assessor should offer the response choices as written and ask the resident to choose one of the responses that most closely aligns with their experience of how often they feel lonely or isolated from those around them.
52	D0700. Social Isolation Look-Back Period	Please consider adding the look-back period for when the question should be asked for D0700. Social isolation.	As noted in Chapter 3, 3.3 Coding Conventions, of the MDS RAI 3.0 v1.18.11 User's Manual, the standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated.

Section GG

#	Topic	Question	Response
53	Section GG Documentation	What will the expectation be for completion of a tool (i.e., GG), for daily documentation of functional status come October? I.e., will it be expected that GG is completed daily to assist in detecting resident changes and having documentation of daily functional status? GG is time consuming to have to use as a daily tool. Trying to process what should be best practice.	Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual, states that the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including to code the items in GG0130. Self-Care and GG0170. Mobility, according to their facility policy and procedure and in compliance with any Federal and State requirements.

54	Section GG Documentation	The RAI User's Manual specifies that the GG assessments should be completed by Qualified Clinicians. Could you please clarify whether there is an expectation that there will be daily documentation of each of the GG functional items by CNAs and other direct care staff who are not qualified clinicians during each look-back? Should the Qualified Clinician be reviewing the CNA documentation and using this data to determine usual performance for each functional item, or is an actual assessment by the Qualified Clinician including direct observation and also interviewing (drilling down) direct care staff to determine the resident's performance that the Qualified Clinician did not personally observe? Basically, are we using a rule of 3 type of determination or, instead, should there be specific functional assessments completed with the resident by the qualified clinicians? Since most residents will not be on therapy's case load during the OBRA assessment windows, is there an expectation that there will be multiple assessors for the functional items, or can one qualified clinician complete the required assessment for GG?	In Chapter 3, Section GG, the term "qualified clinician," is defined as, "Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations." Section GG, under Steps for Assessment, (#6) also states, "Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal and State requirements." The "rule of 3" should not be considered when completing Section GG. Per Section GG Coding Instructions, "When coding the resident's usual performance and discharge goal(s), use the six-point scale, or use one of the four 'activity was not attempted' codes to specify the reason why an activity was not attempted. With this information in mind, consider the following guidance provided in Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual, which states that the RAI process has multiple regulatory requirements regarding the assessment and documentation process. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including to code the items in GG0130. Self-Care and GG0170. Mobility,

#	Topic	Question	Response
			according to their facility policy and procedure and in compliance with any Federal and State requirements.

55	Assessment and Documentation of Section GG	The explanation and instruction that is given now on how you would code makes it sound as though you are not looking at documentation. A clinician is doing an assessment. I think a lot of peers interpret the who, when, and how of Section GG differently. Does GG coding on the MDS have to be completed by an RN?	Guidance for GG steps for assessment specifically references the assessment being conducted by an interdisciplinary team of "qualified clinicians" as defined in the MDS RAI 3.0 v1.18.11 User's Manual, Chapter 3, Section GG: "Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations." The RAI process has multiple regulatory requirements regarding the assessment and documentation process. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual. CMS does not dictate who should complete each section/data element of the MDS, but requires that the facility ensure that those who complete the MDS have the requisite skills. Given the requirements of participation by appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an IDT that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs, and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted an RN waiver under 42 CFR 483.35(e) must provide an RN to conduct or coordinate the assessment and sign off on the assessment as complete. In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts and should also include the resident's medical record, physician, and family, guardian, and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same

#	Topic	Question	Response
			observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.
56	Section GG Documentation	Can you provide more guidance on the amount of documentation needed; who is to provide this documentation for scoring Section GG on the MDS? Is it necessary to document every shift over the 3-day look-back period?	CMS does not impose specific documentation procedures on nursing homes in completing the RAI. While this is the case, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including coding the items in GG0130. Self-Care and GG0170. Mobility, according to their facility policy and procedure and in compliance with any Federal and State requirements. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. Please see Chapter 1, 1.3. Completion of the RAI, in the MDS RAI 3.0 v1.18.11 User's Manual for further details.
57	3-Day Assessment Window for Section GG	Are we allowed to establish and document the final "usual" functional performance for GG AFTER the 3 days documentation?	Completion of Section GG of the MDS (i.e., coding determination) does not need to occur within the 3-day assessment window, but it is expected to be based on assessment(s) completed within the 3-day assessment window. The Interdisciplinary Team (IDT) can assimilate the data to determine "usual performance" after day 3 as long as they only utilize data/information from the 3-day assessment window.
58	Determining the Resident's Usual Ability	If multiple data points are collected under the 3-day observation window, does the clinician completing GG need to collate usual performance score based on most frequent or average?	If the resident performs the activity multiple times and that performance varies during the assessment period, the clinician should use their clinical judgment to determine and record the resident's usual ability to perform any of the self-care or mobility activities in Section GG. Do not record the resident's most independent performance and do not record the resident's most dependent performance, but rather record the resident's usual activity/performance over the assessment period. For further information please refer to Tips for Coding the Resident's Usual Performance, Chapter 3, Section GG of the MDS RAI 3.0 v1.18.11 User's Manual.

#	Topic	Question	Response
59	Determining the Resident's Usual Ability	If therapy can ambulate a resident with recent fracture on days 1-3 of admission but floor staff does not due to safety concerns, do you code usual performance as did not occur or do you use therapy's assessment?	If the resident's functional status varies, the clinician should use their clinical judgment to determine and record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance over the assessment period.
60	Look-Back Period	When coding GG0115 and GG0120, if the ARD was set for day 6, would we only use days 1-6, and not include day 7 as it would extend into the preadmission period?	Per the coding conventions listed in the Chapter 3 Introduction, "With the exception of certain items (e.g., some items in Sections J, K and O), the look-back period does not extend into the preadmission period unless the item instructions state otherwise. In the case of reentry, the look-back period does not extend into time prior to the reentry, unless instructions state otherwise."

#	Topic	Question	Response
61	Look-Back Period	I have a question about Section GG on the MDS, effective 10/1/23. Currently Section GG has to be documented during the look-back period by licensed nurses and Rehab. Effective MDS 10/1/23, can we code CNA documentation for the look-back period for Section GG or does the documentation for Section GG still need to be completed by Nursing during the look-back period for Section GG?	There is no regulatory requirement which specifically states that "Section GG has to be documented during the look-back period by licensed nurses and rehab". Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual, states that the RAI process has multiple regulatory requirements regarding the assessment and documentation process. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including to code the items in GG0130. Self-Care and GG0170. Mobility according to their facility policy and procedure and in compliance with any Federal and State requirements.
62	Look-Back Period	For long-term care (LTC) OBRA assessments do we use 7 days or 3 days and continue to follow the rule of 3?	The look-back period for GG0130 and GG0170 is 3 days and is dependent on the type of assessment and ARD. Refer to Section GG of the MDS RAI 3.0 v1.18.11 User's Manual for specific look-back periods based on the assessment type and ARD. The rule of 3 does not apply to Section GG. Rather, the assessor should follow the coding guidance in Section GG of the RAI 3.0 User's Manual.

#	Topic	Question	Response
63	GG0130 & GG0170	Are Certified Nursing Assistants (CNAs) documenting in GG? Is the look-back period 3 or 7 days, and are we following the rule of 3?	Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual, states that the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including coding the items in GG0130. Self-Care and GG0170. Mobility, according to their facility policy and procedure and in compliance with any Federal and State requirements. The look-back period for GG0130 and GG0170 is 3 days and is dependent on the type of assessment and ARD. Refer to Section GG of the RAI 3.0 User's Manual for specific look-back periods based on assessment type and the ARD. The Rule of 3 does not apply to Section GG. The assessor should follow the coding guidance in Section GG of the MDS RAI 3.0 v1.18.11 User's Manual to complete these data elements.

#	Topic	Question	Response
64	GG0130 & GG0170 Coding	In Section GG0130 and GG0170 Steps for assessment, there is a statement about both columns being required. Could CMS add clarification on which two columns this is referring to? Note: If A0310B = 01 and A0310A = 01 – 06 indicating a 5-day PPS assessment combined with an OBRA assessment, the assessment period is the first 3 days of the stay beginning on A2400B and both columns are required. In these scenarios, do not complete Column 5. OBRA/Interim Performance.	As noted on the GG0130 and GG0170 Admission item sets shown in Chapter 3 of the MDS RAI 3.0 v1.18.11 User's Manual, the assessor will complete columns 1 and 2 when A0310B=1.
65	GG0130 & GG0170	What is the difference between discharge GOAL and actual discharge?	For GG0130. Self-Care and GG0170. Mobility self-performance, a discharge goal is completed on admission based on the determination of a qualified clinician regarding the resident's prior medical condition, admission assessment of self-care and mobility status, discussions with the resident and family, professional judgment, practice standards, expected treatments, the resident's motivation to improve, anticipated length of stay, and the resident's discharge plan. The coding of discharge self-performance for self-care and mobility is similar to the coding of self-performance for self-care and mobility on admission. Coding for self-performance on discharge is related to the ability of the resident to complete the listed functional activities and how much help (if any) is required to complete them. For more information, please refer to Section GG in Chapter 3 of the MDS RAI 3.0 v1.18.11 User's Manual, which provides extensive explanation regarding the coding of Admission Performance, Discharge Goal, and Discharge Performance.

#	Topic	Question	Response
66	GG0130. Self-Care	What section would personal hygiene of daily perineal care be coded?	The item GG0130I. Personal Hygiene does not capture the performance of perineal care. Rather, it involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands (excludes baths, showers, and oral hygiene). Perineal care provided in conjunction with use of the toilet, commode, bedpan, or urinal is captured in GG0130C. Toileting Hygiene. For additional details regarding toileting hygiene and perineal cleansing, please refer to the Section GG coding guidance in the MDS RAI 3.0 v1.18.11 User's Manual for GG0130. Toileting Hygiene.
67	GG0130. Self- Care	Returning personal items to their toiletry bag would be clean up? So why not set up?	In GG0130I Practice Scenario 1, the resident removed their personal hygiene needs from the toiletry bag, but the CNA returned them to the toiletry bag due to resident's upper arm weakness.
68	GG0130E. Shower/Bathe Self	What should be coded if the resident didn't receive a bath/shower the first 3 days?	If the resident did not receive a bath/shower because the resident did not attempt the activity and a helper did not complete the activity for the resident during the entire assessment period, GG0130E. Shower/bathe self would be coded with one of the "activity not attempted" codes (07, 09, 10, or 88). If the resident did not receive a bath/shower because they were not scheduled for one during the entire assessment period, the assessment did not occur and GG0130E. Shower/bathe self would be coded with a dash (-). A dash value indicates that the data element was not assessed and therefore no information is available.
69	GG0130E. Shower/Bathe Self	If a resident usually receives a shower/bath, but is not offered one during the 3-day window (because it is not scheduled), how do you code? Instruction states to use one of the did not occur codes, but they don't exactly fit. Unless "lack of scheduling" is considered an environmental limitation. We don't want to use a dash, as this impacts the QRP.	If the resident did not receive a bath/shower because the resident did not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, GG0130E: Shower/bathe self would be coded with one of the "activity not attempted" codes (07, 09, 10, or 88). If the resident did not receive a bath/shower because they were not scheduled for one during the entire assessment period, the assessment did not occur and GG0130E: Shower/bathe self would be coded with a dash (-). A dash value indicates that the data element was not assessed and therefore no information is available.
70	GG0130I. Personal Hygiene	Should the resident’s ability to take a partial bath at the sink (e.g., washing underarms, trunk, and perineal area) be coded as part of personal hygiene?	Personal hygiene involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands. It excludes baths, showers, and oral hygiene.

#	Topic	Question	Response
71	GG0170FF. Tub/shower Transfer	If the resident calls for a CNA before they transfer out of the tub, would that be considered Supervision?	If the resident just calls for a CNA before transferring out of the tub, that alone would not qualify as supervision. The definition of Code 4, Supervision or touching assistance indicates that the helper would provide verbal cues or touching/steadying and/or contact guard assistance as the resident completes the activity. Therefore, once the CNA has responded to the resident's call for assistance, the assessor should code GG0170FF. Tub/shower transfer, using clinical judgment and the guidance provided in the MDS RAI 3.0 v1.18.11 User's Manual to determine the level of assistance provided to the resident while they transfer out of the tub and code accordingly.
72	GG0170FF. Tub/Shower Transfer	If the CNA puts the resident in a shower chair prior to leaving the resident's room, how do you code GG0170FF. Tub/shower transfer?	GG0170FF. Tub/shower transfer involves the ability to get into and out of the tub or shower. It does not include transferring the resident onto a tub/shower chair prior to bringing them to the tub/shower or ambulating the resident to and from the shower room. Once the resident is in the shower/tub room, the assessor should determine the resident's ability to get into and out of the tub/shower, including whether helper assistance was required (if any), and code GG0170FF using the appropriate response code from the six-point scale definitions. If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, use one of the “activity not attempted” codes. If none of the response codes from the six-point scale nor the “activity not attempted” codes applies, this data element should be coded with a dash (-) to denote that the data element was not assessed and therefore no information is available.
73	GG0170FF. Tub/shower Transfer	In scenario 4 for GG0170FF, the nurse does not specify in the question “over the past 3 days.” Does the interviewing nurse have to interview on the last day of the 3-day look back?	Data collected on self-care and mobility performance is based on direct observation and reports from qualified clinicians or care staff that occurred during the assessment period. For example: The scenario states that during the 3-day observation period for a resident’s Quarterly assessment, the nurse asked the resident’s primary CNA if they can describe how the resident usually transfers in and out of the shower. The nurse would indicate the assessment period to the CNA or others that they interview as part of the assessment period to ensure accurate data.

#	Topic	Question	Response
74	GG0170FF. Tub/Shower Transfer	For GG0170FF. Tub/shower transfers, if a resident was transported to the shower on a shower chair or walked to the shower and then sat on a shower chair, would this be considered in the coding of this item?	Tub/shower transfer involves the ability to get into and out of the tub or shower. It does not include how the resident gets to the shower/tub room. Code only based on how the resident gets into and out of the tub/shower.
75	GG0170N. 4 Steps and GG0170O. 12 Steps	GG0170M – GG0170O Coding tip clarifications: Could CMS please provide some examples of safe situations in which a wheelchair is used to go up or down 4 or 12 steps? If a resident requires a helper to provide total assist (for example, the resident requires total assist from a helper to move up and down over a curb in their wheelchair), code as 01, Dependent. A resident who uses a wheelchair may be assessed going up and down stairs (including one step/curb) in a wheelchair. Code based on the type and amount of assistance required from the helper. This following bullet seems to contradict the previous instruction. If the resident was unable to complete the activity due to a physician prescribed restriction, why couldn't the code of dependent be used if the staff assisted over a curb or up or down stairs safely in a wheelchair? If, at the time of the assessment, a resident is unable to complete the activity because of a physician prescribed restriction (for instance, no stair climbing for two weeks) but could perform this activity prior to the current illness, exacerbation, or injury, code 88, Not attempted due to medical condition or safety concern.	The intent of Section GG stair activities is to assess the resident's ability to go up and down 1 step/curb, 4 steps, and 12 steps. Completing the stair activities indicates that a resident goes up and down the stairs, by any safe means, with or without any assistive devices (for example, railing or stair lift) and with or without some level of assistance. Going up and down stairs by any safe means includes the resident walking up and down stairs on their feet or bumping/scooting up and down stairs on their buttocks. A resident who is a wheelchair user may be assessed going up and down stairs (including 1 step/curb) in a wheelchair. Code based on the type and amount of assistance the resident required from the helper to complete the activity. If at the time of the assessment the resident is not able to walk up and down the steps due to a medical restriction of no stair climbing, they may be able to complete the stair activities safely by another means (e.g., stair lift, bumping/scooting on their buttocks). If so, code based on the type and amount of assistance required to complete the activity. If, at the time of the assessment, a resident is unable to complete the stair activities because of a physician prescribed bedrest, code the stair activities using the appropriate "activity not attempted" code.

#	Topic	Question	Response
76	GG0170N. 4 Steps and GG0170O. 12 Steps	I am going through the CMS GG training. It states, "If the assessment of going up the stairs and then down the stairs occurs sequentially, the resident may take a standing or seated rest break between ascending and descending the 4 steps or 12 steps." Does this mean the resident could do 4 steps one day, and on each of the two following days, and be considered to have completed the 12 Steps item?	The instruction “If the assessment of going up the stairs and then down the stairs occurs sequentially, the resident may take a standing or seated rest break between ascending and descending the 4 steps or 12 steps” means that if a resident is being assessed for their ability to ascend and descend 4 steps or ascend and descend 12 steps and needs a brief standing or seated rest between ascending and descending, they may take one. It does not mean that the resident can be assessed doing 4 steps on one day, and 4 steps on each of the two following days to complete the 12 Steps data element. The stair activity must be completed in a single episode.
77	GG0170I. Walk 10 Feet	The RAI manual says that a resident cannot be "dependent" with walking but still allows coding "dependent" when using a two-person assist. Can you please clarify?	A resident cannot be dependent in walking because the walking activity cannot be completed without some level of resident participation that allows resident ambulation to occur for the entire stated distance. That is, a helper cannot complete a walking activity for a resident. However, if the assistance of two or more helpers is required for the resident to complete the activity, you would code 01, Dependent. For the walking activity: • If a resident requires the assistance of two or more helpers to ambulate the stated distance, or if two helpers are required for the safe completion of the walking activity (even if the second helper provides only supervision/stand-by assist) you would code 01, Dependent. • You would also code 01, Dependent if a resident requires the assistance of two helpers—one to provide support and a second to manage necessary equipment to allow the walking activity to be completed.

#	Topic	Question	Response
78	GG0170K. Walk 150 Feet and GG0170S. Wheel 150 Feet	In Section GG, an additional coding tip was added for GG0170K. Walk 150 feet, and GG0170S. Wheel 150 feet, that if the environment does not accommodate this activity, but the resident demonstrates the ability to complete this task safely, to code with 6-point scale. This seems to contradict the coding instruction for assessment of usual performance that states “Code based on the resident’s performance. Do not record the staff’s assessment of the resident’s potential capability to perform the activity.” Will CMS consider clarifying the instruction to align with the new coding instructions for Walk or Wheel 150 feet?	The intent of GG0170K. Walk 150 feet is to determine a resident’s ability, once in a standing position, to walk 150 feet in a corridor or similar space. A walking activity cannot be completed without some level of resident participation that allows resident ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a resident. Clinicians can use clinical judgment to determine how the actual resident assessment of walking is conducted. When coding GG0170K. Walk 150 feet, if the resident’s environment does not accommodate a walk of 150 feet without turns, but the resident demonstrates the ability to walk with or without assistance 150 feet with turns without jeopardizing the resident’s safety, code using the 6-point scale. In response to your question about GG0170S. Wheel 150 feet: The intent of GG0170S. Wheel 150 feet is to assess the resident’s ability, once seated in wheelchair/scooter, to wheel at least 150 feet in a corridor or similar space. If a resident’s environment does not accommodate wheelchair or scooter use for 150 feet without turns, but the resident demonstrates the ability to mobilize a wheelchair or scooter with or without assistance for 150 feet with turns without jeopardizing the resident’s safety, code GG0170S. Wheel 150 feet using the 6-point scale.

#	Topic	Question	Response
79	Wheelchair Mobility Items	Can CMS clarify when GG0170Q3 and GG0170Q5 would be assessed? Does the resident have to be learning how to self-mobilize the WC during the 7-day look-back for these subsequent assessments in order to code Yes? The intent of the wheelchair mobility items is to assess the ability of residents who are learning how to self-mobilize using a wheelchair or who used a wheelchair for self-mobilization prior to admission. Use clinical judgment to determine whether a resident's use of a wheelchair is for self-mobilization as a result of the resident's medical condition or safety. If the resident used a wheelchair for self-mobilization prior to admission to the facility, indicate 1, Yes, to the gateway wheelchair items on the initial assessment in GG0170Q1. The responses for gateway wheelchair items (GG0170Q1, GG0170Q3, and/or GG0170Q5) do not have to be the same on subsequent assessments. For example, the Admission Assessment may indicate that the resident does not use a wheelchair, but the subsequent assessment may indicate that the resident uses a wheelchair.	The assessor should code GG0170Q3 and GG0170Q5 to indicate whether a resident uses a wheelchair or scooter unless the wheelchair is used for transport purposes only. The MDS RAI 3.0 v1.18.11 User's Manual provides several coding tips, and the example for GG0170Q1 in Chapter 3 assists further in clarifying when this item would be indicated for coding.
80	Steadying vs. Supporting Assistance	What's the difference between "steadying" and "supporting" a shaky hand?	Steadying is a light guiding of a limb, for example, vs. supporting the weight of a limb.
81	Section GG	Can CMS please clarify how the following is applied using Section GG: Functional abilities and goals, under "Some Guidelines to Assist in Deciding if a Change is Significant or Not"?	The CMS team has identified that the examples in Chapter 2 referring to ADL physical functioning refer to language used in Section G and has updated this for the final version of the MDS RAI 3.0 v1.18.11 User's Manual.

#	Topic	Question	Response
82	Care Area Trigger Specifications	Care Area Trigger (CAT) Logic triggers that now use GG, are only triggering from column 5. The OBRA Admission assessment uses GG column 1, while the Significant Change in Status Assessment (SCSA), Annual, and Significant Correction to Prior Comprehensive Assessment (SCPA) use column 5. The logic in the draft would not allow residents to trigger care areas on the admission assessment. The following care areas are affected: 5. ADL Functional/Rehabilitation Potential, 6. Urinary Incontinence, and 16. Pressure Ulcer/Injury. Note: the recently released CAT Specifications V1.06.0, do include both columns 1 and 5.	CMS has aligned the final MDS RAI 3.0 v1.18.11 User's Manual with the CAT Specifications V1.06.0.
83	Retirement of Section G	Is Section GG replacing Section G?	Section G has been retired. Some data elements from Section G were retained and integrated into Section GG. Please be sure to review the didactic presentation for Section GG that reviews the data elements that have been added to Section GG.

Section J

#	Topic	Question	Response
84	J0510–J0530 Pain Assessment Interview	If a resident is unable to complete the Pain Assessment Interview, and you code 0, why would you answer the J0510–J0530 with code 8 or 9 "unable to answer"? I thought you would skip to the Staff Assessment for Pain?	As stated in the Steps for Assessment for the Pain Assessment Interview (J0300–J0600), assessors should interview any resident not screened out by the Should Pain Assessment Interview Be Conducted? Item (J0200). The Pain Assessment Interview for residents consists of seven items: the primary question Pain Presence item (J0300) and six follow-up questions. If the resident is unable to answer the primary question on the Pain Presence item J0300, skip to the Staff Assessment for Pain, beginning with the Indicators of Pain or Possible Pain item (J0800). For the follow-up questions that are part of the Pain Assessment Interview, if the resident is unable to respond, does not respond, or gives a nonsensical response, the assessor should use the appropriate “Unable to answer” code for the item.
85	J0300–J0600 Pain Assessment Interview	Why would an assessor do a pain assessment for the MDS on the day of admission?	The pain assessment should be conducted during the 7-day look-back period depending on when the interdisciplinary team sets the Assessment Reference Date (ARD). If the ARD is set early in the resident stay (e.g., day 1 or 2), the resident would reflect on their pain in the past 5 days, just as if the ARD were later in their stay in the facility.
86	J0300–J0600 Pain Assessment Interview	For the Pain Assessment Interview questions, are there provisions for returning at another time and conducting the interview if the resident is not able or doesn't want to answer at the time of the initial approach?	The assessor should use clinical judgment to determine if the resident refused to participate in the interview due to circumstances such as symptoms of illness, pain, etc., or if they prefer not to take part at any time and proceed accordingly.

#	Topic	Question	Response
87	J0300–J0600 Pain Assessment Interview	Can we use staff interviews for gathering information on resident pain?	J0300–J0600: Pain Assessment Interview should be completed based on resident self-report only. If item J0200. Should Pain Assessment Interview Be Conducted? is coded 0 because the resident is rarely/never understood or an interpreter is required but not available, or the resident is unable to answer the primary question on item J0300. Pain Presence, the assessor will skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain (item J0800). When completing J0850. Frequency of Indicator of Pain or Possible Pain, the assessor will review the medical record and interview staff and direct caregivers to determine the number of days the resident either complained of pain or showed evidence of pain, as described in J0800, in the last 5 days. Most residents who are capable of communicating can answer questions about how they feel. Obtaining information about pain directly from the resident is more reliable and accurate than observation alone for identifying pain. Interview allows the resident's voice to be reflected in the care plan. Information about pain that comes directly from the resident provides symptom-specific information for individualized care planning.
88	Pain Assessment Interview	Is there a staff and/or family interview for assessing pain?	Assessors should interview any resident not screened out by item J0200. Should Pain Assessment Interview Be Conducted? The Pain Assessment Interview items are resident self-report items. Most residents who are capable of communicating can answer questions about how they feel. Obtaining information about pain directly from the resident is more reliable and accurate than observation alone for identifying pain. Interview allows the resident's voice to be reflected in the care plan. Information about pain that comes directly from the resident provides symptom-specific information for individualized care planning. For residents screened out by J0200, complete J0800. Indicators of Pain, which is coded based on staff observation of pain indicators.

#	Topic	Question	Response
89	Pain Assessment Interview	Can a chart review be used for coding the Pain Assessment Interview items; for example, if the resident is unable to recall how much pain has interfered with their sleep, therapy, and day-to-day activities?	As stated in the Steps for Assessment for the Pain Assessment Interview, directly ask the resident each item in the Pain Assessment Interview in the order provided. Use other terms for pain or follow-up discussion if the resident seems unsure or hesitant. Some residents avoid use of the term "pain" but may report that they "hurt." Residents may use other terms such as "aching" or "burning" to describe pain. If the resident chooses not to answer a particular item, accept their refusal, code it as 8, and move on to the next item.
90	Pain Assessment Interview	How should you code the pain assessment interview if staff reports of a resident's pain directly conflict with what the resident states regarding their pain?	Data elements J0510–J0530 should be coded based on the resident's interpretation of the provided response options for frequency.
91	Pain Assessment Interview	In J0510. Pain Effect on Sleep: If a resident reports that they cannot remember their pain experience and then later states they don't want to discuss it any further, should the nurse continue to ask the resident probing questions about the resident's recall of pain?	Per the Steps for Assessment for the Pain Assessment Interview, if the resident chooses not to answer a particular item, the assessor should accept their refusal, code it as 8, and move on to the next item.
92	Pain Assessment Interview Look-Back Period	Can the look-back period for the Pain Assessment Interview include days when the resident was in the hospital and not yet admitted to the SNF? For example, if a resident was in the hospital from 9/6 to 9/10/23 before being admitted to the SNF on 9/10/2023, and the ARD was set as 9/12/2023, is it correct that the 7-day look-back period would include days when the resident was in the hospital?	Yes, this is correct. The Pain Assessment Interview, which includes items J0510–J0530, asks the resident to recall pain in the past 5 days. Staff should conduct the pain assessment during the 7-day look-back period. The resident's response should be based on their pain recall in the past 5 days.
93	Pain Assessment Interview Look-Back Period	What is the look-back period for the Pain Assessment Interview items J0510, J0520, and J0530?	The Pain Assessment Interview, which includes items J0510–J0530, asks the resident to recall pain in the past 5 days. Staff should conduct the pain assessment during the 7-day look-back period. The resident's response should be based on their pain recall in the past 5 days.
94	J0200. Should Pain Assessment Interview be Completed?	For the Section J Pain Assessment Interview items, what should we do if a resident is rarely understood and unable to answer the questions?	If J0200. Should Pain Assessment Interview Be Conducted? is coded 0, No, because the resident is rarely/never understood or an interpreter is required but not available, the assessor will skip to item J0800. Indicators of Pain or Possible Pain.

#	Topic	Question	Response
95	J0520. Pain Interference with Therapy Activities	I am watching the CMS videos and have a question about the new question on Section J regarding pain with therapy activities. I saw where it says to include pulmonary therapy. Our company has a facility with ventilators that require 24-hour respiratory therapy (RT). Would we assess for pain on our vent dependent residents during breathing therapy, trach care, suction, etc. on this item set?	Per the Coding Instructions for J0520. Pain Interference with Therapy Activities, code for pain interference with therapy activities over the past 5 days. Rehabilitation therapy services includes, but is not limited to, special healthcare 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 can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies. While rehabilitation therapy considered for this item includes respiratory therapy, including the modalities that you noted, it is important to remember that item J0520 is a resident interview item. If the resident with a continuous ventilator is appropriate for an interview (as documented in J0200. Should Pain Assessment Interview Be Conducted?), they should consider how pain interfered with any types of therapy that they received over the past five days.
96	J0520. Pain Interference with Therapy Activities	For J0520. Pain Interference with Therapy Activities, does the question "limited your participation in rehabilitation therapy sessions due to pain" mean that the resident has not participated in therapy at all, or that the resident has not participated in therapy to their fullest ability?	For item J0520. Pain Interference with Therapy Activities, code for pain interference with therapy activities over the last 5 days. This item should be coded based on the resident's interpretation of the provided response options for frequency.
97	J0520. Pain Interference with Therapy Activities	If an assessor knows that a resident is not receiving rehabilitation therapy, would the assessor still have to ask the resident item J0520. Pain Interference with Therapy Activities?	J0300–J0600: Pain Assessment Interview, should be completed based on resident self-report only. The assessor should follow the Steps for Assessment when completing the Pain Assessment Interview. Directly ask the resident each item in the order provided. Directly asking the resident about pain rather than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain.
98	J0520. Pain Interference with Therapy Activities	Are physical therapy (PT) and occupational therapy (OT) maintenance programs considered when coding J0520. Pain Interference with Therapy Activities?	Yes, maintenance therapy provided by a skilled therapist is considered when coding J0520. Pain Interference with Therapy Activities.

#	Topic	Question	Response
99	J0520. Pain Interference with Therapy Activities	In the Section J Coding Workshop scenario 3, the answer was to code "does not apply" since the resident was not receiving therapy due to a foot infection and IV antibiotics. Is this answer the correct choice because it is what the resident said, even if it is known that the resident's response may be confused?	J0300–J0600: Pain Assessment Interview, which includes item J0520. Pain Interference with Therapy Activities, is an interview with the resident to assess pain. The interview items are intended to be self-report items. Resident self-report is the most reliable means for assessing pain. In this scenario, the resident was not confused and reported that they had not begun receiving rehabilitation therapy due to a foot infection and IV therapy. Therefore, the most applicable response is Code 0, Does not apply, since the resident is not participating in rehabilitation therapy for reasons unrelated to pain.
100	J0520. Pain Interference with Therapy Activities	How should J0520. Pain Interference with Therapy Activities be coded if the resident has difficulty distinguishing between when in therapy and other activities?	J0300–J0600: Pain Assessment Interview, which includes item J0520. Pain Interference with Therapy Activities, is an interview with the resident to assess pain. The interview items are intended to be self-report items. Resident self-report is the most reliable means for assessing pain. When coding J0520, assessors should read the question and response choices as written. Code for pain interference with therapy activities over the past 5 days. Note that this item should be coded based on the resident's interpretation of the provided response options for frequency. Should the resident need clarification as to what is included in rehabilitation therapy, the assessor is not precluded from providing it.
101	J0520. Pain Interference with Therapy Activities	For the pain interview, can staff provide the definition of "rehabilitation therapy" to the resident or is the interview based on the resident's interpretation of this term? CMS provided a definition of "rehabilitation therapy" to include cardiac and pulmonary therapies in addition to physical therapy, occupational therapy, and speech therapy. It is unlikely that residents will consider clinical-related therapy in this question.	As noted in the Steps for Assessment for J0520 in the MDS RAI 3.0 v1.18.11 User's Manual, the assessor should read the question and response choices as written. Should the resident need clarification as to what is included in rehabilitation therapy, the assessor is not precluded from providing it.

#	Topic	Question	Response
102	Restorative Programs	Do Restorative Programs count for J0520. Pain Interference with Therapy Activities? The list of examples in the definition of Rehabilitation Therapy states that Rehabilitation Therapy can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.	No, restorative programs do not count for J0520. Pain Interference with Therapy Activities. The MDS RAI 3.0 v1.18.11 User's Manual provides information on restorative nursing programs. A resident may be started on a restorative nursing program when they are admitted to the facility with restorative needs but are not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. The MDS RAI 3.0 v1.18.11 User's Manual defines rehabilitation therapy as special healthcare 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 can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies. Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff or the resident carrying out a prescribed therapy program without staff members present.

Section K

#	Topic	Question	Response
103	Therapeutic Diets	Is a lactose-free or gluten-free diet considered therapeutic since it does not alter micro- or macro-nutrients? But it is used as part of treatment for a disease or medical condition.	Therapeutic diets are not defined by the content of what is provided or when it is served, but *why* the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition (e.g., irritable bowel syndrome, celiac disease) that is manifesting an altered nutritional status, by providing the specific nutritional requirements to remedy the alteration. If the resident receives a lactose-free or gluten-free diet to address a particular disease or clinical condition, it is considered therapeutic, and the assessor should capture it in K0520D. Therapeutic diet.
104	Mechanically Altered Diet Trial	Can you clarify what the definition of "trial" for mechanically altered diet is? Does it have to be Speech Language Pathologist (SLP) directed? Assessors should not capture a trial of a mechanically altered diet (e.g., pureed food, thickened liquids) during the observation period in K0520C. Mechanically altered diet.	This data element captures information regarding whether the resident requires food to be specifically prepared to alter the texture or consistency to facilitate oral intake. A "trial" of certain textures would be used to determine the necessity of a mechanically altered diet, but not whether the mechanically altered diet was eventually required or ordered.
105	Feeding Tubes	Regarding Section K, feed tube, can we still capture its presence even if we are giving water flushes only?	In K0520B. Feeding tube, check only if the feeding tube is being used to deliver nutritive substances and/or hydration during the assessment period.
106	Feeding Tubes	For K0520. Nutritional Approaches, would B, Feeding Tube be checked whether a feeding tube was in use vs. physically removed?	Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B. Feeding tube.
107	Coding Nutritional Supplements	Are nutritional supplements included for coding in Section K?	Per the MDS RAI 3.0 v1.18.11 User's Manual, Chapter 3, Section K, Coding Tips for K0520D, A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status does not constitute a therapeutic diet but may be part of a therapeutic diet. Therefore, supplements (whether given with, in between, or instead of meals) are only coded in K0520D. Therapeutic diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g., supplement for protein-calorie malnutrition).

#	Topic	Question	Response
108	K0520. Nutritional Approaches	For K0520 columns 1 and 4, will those only appear on MDSs that include the 5-day PPS assessment?	For K0520. Nutritional Approaches, Column 1, On Admission, and Column 4, At Discharge, are to be completed for PPS stays only. These columns will appear on the appropriate item sets. Software vendors may have different user interfaces that do not mimic the paper configuration of the item sets, but they are required by CMS to include all data elements required for completion of the appropriate assessment(s).
109	K0520. Nutritional Approaches	For K0520. Nutritional Approaches, what type of documentation would be appropriate to support coding intravenous fluids (IVF)?	As stated in the MDS RAI 3.0 v1.18.11 User's Manual, item K0520A includes any and all nutrition and hydration received by the nursing home resident during the observation period either at the nursing home or at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration. • Supporting documentation should be noted in the resident's medical record as defined by the facility policy and/or according to State and Federal regulations. • The supporting documentation is for specific fluids that may be included when there is documentation reflecting the need for additional fluid intake specifically addressing a nutrition or hydration need.
110	K0520. Nutritional Approaches	Will the last 3-day column require an assessment or nutrition note for the last 3 days of PPS? We have the initial assessment, readmission, and significant change assessments, but do we have to complete it prior to discharge?	For K0520, Column 4, At Discharge, check all nutritional approaches performed within the last 3 days of the SNF PPS Stay. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

#	Topic	Question	Response
111	K0520. Nutritional Approaches	For fluids administered in the hospital, do you have to have documentation mentioning hydration in the notes or in the medical record? If there is no documentation, can you still code the IV fluids?	The instructions for K0520. Nutritional Approaches, for Column 2, While Not a Resident, have not changed. Only the column number has changed. For this column, check all nutritional approaches performed prior to admission/entry or reentry to the facility and within the 7-day look-back period. Column 2 is left blank if the resident was admitted/entered or reentered the facility more than 7 days ago. K0520A includes any and all nutrition and hydration received by the nursing home resident during the observation period either at the nursing home or at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration. Supporting documentation should be noted in the resident's medical record as defined by the facility policy and/or according to State and Federal regulations.
112	K0520. Nutritional Approaches	In your coding tips for K0520, it stated NOT to capture a trial of mechanically altered diet. In your practice scenario, you captured it. Please explain further.	In K0520 Coding Workshop: Practice Scenario 2, the resident slowly progressed on a mechanically altered diet during their 3-week stay (21 days) and was placed on a regular diet on Day 10. This was not a trial but was part of the process for progressing from daily tube feedings to oral intake.
113	K0520. Nutritional Approaches	Is a Mechanical Soft diet considered Mechanically altered? The food was not altered.	Yes, such a diet meets the requirements for coding mechanically altered diet on the MDS. The definition of a mechanically altered diet included in Chapter 3, Section K, of the MDS RAI 3.0 v1.18.11 User's Manual states that it is a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. These textures/consistencies are consistent with what the National Dysphagia Diet considers a mechanically altered diet. Textures/consistencies mentioned in this diet include moist, semi-solid foods such as cooked cereals with little texture, moistened ground or cooked meat, and moistened, soft, easy to chew canned fruit and vegetables. You can access the National Dysphagia Diet here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3426263/.
114	K0520. Nutritional Approaches	Please clarify that the last 3 days of PPS stay for the nutritional approaches do not include the day of discharge but is the last 3 days ending on the last Medicare covered day.	For K0520. Nutritional Approaches, Column 4, At Discharge, check all nutritional approaches performed within the last 3 days of the SNF PPS Stay ending on A2400C. End Date of Most Recent Medicare Stay.

#	Topic	Question	Response
115	K0520. Nutritional Approaches	For Practice Scenario 2 Part 2, why wouldn't mechanically altered diet be coded in Column 3, While a Resident? It says they were "progressed on a mechanically altered diet".	Coding Instructions in the MDS RAI 3.0 v1.18.11 User's Manual for Section K, item K0520, state to check all nutritional approaches performed after admission/entry or reentry to the facility and within the 7-day look-back period. Based on the scenario presented, the resident was discharged on day 21. Although they progressed on a mechanically altered diet earlier in the stay, they were placed on a regular diet on day 10. The look-back for the “While a resident” on a discharge assessment would be the day of discharge (day 21) and the prior 6 days (days 15-20). Because the mechanically altered diet ended on day 10, this would not be captured in the look-back period for "While a Resident." Had the mechanically altered diet been received during that 7-day look-back period, it would have been captured.
116	K0520. Nutritional Approaches	For K0520. Nutritional Approaches, does “At Discharge” (column 4) ask what the diet was on the day of discharge or is it asking what diet was ordered for the resident to continue on after they are discharged?	At discharge, providers are to check all nutritional approaches listed that were performed within the last 3 days of the SNF PPS Stay, ending on A2400C. End Date of the Most Recent Medicare Stay. Therefore, this column is not meant to collect data on nutritional approaches that may occur after discharge.
117	K0520. Nutritional Approaches	How do I code K0520. Nutritional Approaches, if a resident’s diet changes after admission to a SNF for a PPS stay but before day 3 from a regular diet to a therapeutic diet?	For the new column, “On Admission” (column 1), one would check all nutritional approaches performed during the first 3 days of the SNF PPS Stay. Therefore, if after admission a new order was received and the resident was started on a therapeutic diet in the first 3 days of the SNF PPS stay, therapeutic diet may be checked in K0520.

Section M

#	Topic	Question	Response
118	Kennedy Terminal Ulcers	Please clarify the new Kennedy Terminal Ulcers (KTU) coding tip. It states that KTUs are not coded in Section M. Does this mean the pressure ulcer developed while the resident was actively dying? What if these pressure ulcers are in pressure areas? What would be an example of good documentation for KTU?	Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs), are the result of an unavoidable skin breakdown associated with organ failure that occurs as part of the dying process and usually associated with imminent death. These ulcers are not primarily caused by pressure and are not coded in Section M. CMS does not determine how assessment information is documented but does expect the facility to document accurately, remaining in compliance with the requirements of the Federal regulations and the instructions contained within the MDS RAI 3.0 v1.18.11 User's Manual. Although CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS.
119	Staging Pressure Ulcers on Admission	The draft instructions for the steps for assessment of staging pressure ulcers/injuries added: "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" The step continues to state, "Do not reverse or back-stage. Consider current and historical levels of tissue involvement." If there is medical record documentation regarding historic levels of tissue involvement from a previous provider prior to admission to the nursing facility, how is the historical information used when staging the pressure ulcer on admission?	As noted in Chapter 3, Steps for completing M0300A-G of the MDS RAI 3.0 v1.18.11 User's Manual, assessors should "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."

#	Topic	Question	Response
120	Healed Pressure Ulcer	The draft manual added instructions to item M0300, “Step 1: Determine Deepest Anatomical Stage,” part 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.” Can CMS please clarify if there is a difference between a closed pressure ulcer and a pressure ulcer that has healed? The instructions from the M0100 Item Rationale, noted below, indicates that the term “closed” only refers to healed pressure ulcers in some instances: • Throughout this section, terminology referring to “healed” versus “unhealed” ulcers refers to whether or not the ulcer is “closed” versus “open.” When considering this, recognize that Stage 1, Deep Tissue Injury (DTI), and unstageable pressure ulcers although “closed” (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered “healed.” • Definition box for healed pressure ulcer: Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.	As you've noted, CMS defines a healed pressure ulcer as an ulcer that is “completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration”.

Section N

#	Topic	Question	Response
121	N0415. High-Risk Drug Classes: Use and Indication	Please clarify medication indications; does it have to be the classified indication or is an off use acceptable, such as Metoprolol for asthma?	Indication is defined as the identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals. Nursing home teams should work with the resident's physician to determine the indications for each medication included in the resident's medication regimen, especially if uncertain of the indication for medications ordered. Additionally, they can refer to Appendix PP of the State Operations Manual (SOM) for guidance around indications for medications. The SOM can be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf.
122	N0415. High-Risk Drug Classes: Use and Indication	Clozapine; is it not classified as antipsychotic? Did I get the med incorrect? Classified in webinar as antiplatelet.	Practice Scenario 2 identifies clozapine as being taken for bipolar disorder and is coded as an antipsychotic in N0415A1 and N0415A2. The antiplatelet medication coded in N0415I and N0415I2 in this scenario is the aspirin, which is being taken for the resident's cardiovascular disease.
123	N0415. High-Risk Drug Classes: Use and Indication	If Benadryl is prescribed for itching, how do you code this in Section N? Benadryl is classified as both antihistamine and hypnotic/sedative.	For N0415, code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories as available regardless of how they are being used. This guidance has not changed and can be found under Coding Tips and Special Populations in Section N of the MDS RAI 3.0 v1.18.11 User's Manual.
124	N0415. High-Risk Drug Classes: Use and Indication	Can someone clarify what classification Melatonin is?	Melatonin is a synthetic over-the-counter supplement. Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (i.e., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (i.e., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root). For clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products and to monitor their potential effects as they can interact with medications the resident is currently taking. For more detailed information, please refer to Section N, N0415 Coding Tips, in the MDS RAI 3.0 v1.18.11 User's Manual.

#	Topic	Question	Response
125	N0415. High-Risk Drug Classes: Use and Indication	Can you clarify if an indication must be documented for each medication in a class in order to check it?	In Column 1, for all medications in the drug class that are checked, check in Column 2 if there is a documented resident-specific indication noted. Chapter 3, Section N, Steps for Assessment for N0415, provides additional information: 1. Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room).
126	N0415. High-Risk Drug Classes: Use and Indication	Can you confirm if having a proper diagnosis is not an indication of use?	An indication is defined as the identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals. In addition, in Chapter 3, Section N, under Planning for Care for item N0415, the MDS RAI 3.0 v1.18.11 User's Manual states: "The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological interventions, are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s) since a diagnosis alone may not warrant treatment with medication."
127	N0415. High-Risk Drug Classes: Use and Indication	What is an acceptable supporting documentation for Indication in N0415?	Indication is defined as the identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals. You may find this information in the resident's medical record or upon review of documentation from other health care settings where the resident may have received any of these medications.
128	N0415. High-Risk Drug Classes: Use and Indication	If a diagnosis code is attached to the medication does an indication still need to be indicated?	Indication is defined as the identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals. You may find this information in the resident's medical record or upon review of documentation from other health care settings where the resident may have received any of these medications. Chapter 3, Section N, under Planning for Care for item N0415, in the MDS RAI 3.0 v1.18.11 User's Manual states: "The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological interventions, are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s), since a diagnosis alone may not warrant treatment with medication."

#	Topic	Question	Response
129	N0415. High-Risk Drug Classes: Use and Indication	Sometimes medications fall into multiple categories and are used for off label purposes; how should they be coded?	For N0415, in Column 1, "Is taking," code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories as available, regardless of how they are being used. For Column 2, "Indication noted," check if there is an indication noted for all medications in the drug class. An indication is defined as the identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.
130	Herbal and Alternative Medicine Products	If a resident is taking St. John's Wort, would this be coded as an antidepressant for N0415?	As stated in the Coding Tips and Special Populations for N0415. High-Risk Drug Classes, herbal and alternative medicine products (e.g., melatonin, chamomile, valerian root) are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (i.e., they are not reviewed for safety and effectiveness like medications), and their composition is not standardized (i.e., the composition varies among manufacturers). Therefore, they should not be counted as medications. Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects because they can interact with medications the resident is currently taking. For more information consult the FDA website http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/.
131	Coding Column 2, Indication Noted	For N0415. High-Risk Drug Classes: Use and Indication, if a resident is taking two antipsychotic medications but there is only an indication noted for one, should Column 2, Indication noted be checked?	N0415. High-Risk Drug Classes: Use and Indication identifies if the resident is taking any prescribed medications in the specified drug classes and whether the indication was noted for all medications in the drug class. Per the scenario, you would not check Column 2, Indication noted, as there is not an indication noted for all antipsychotic medications taken by the resident at any time during the observation period (or since admission/entry or reentry if less than 7 days).
132	Antiplatelet vs. Anticoagulant Medications	For N0415, if a resident is taking a medication classified as an antiplatelet, would it be included in the coding of N0415E. Anticoagulant?	Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E. Anticoagulant. Medications taken by a resident classified as antiplatelet should be coded as N0415I. Antiplatelet.

#	Topic	Question	Response
133	Definition of Indication	In item N0415, can you please give a definition for “indication” for use?	For N0415, Column 2, Indication noted, for all classes checked in Column 1, Is taking, you are to check the box if there is an indication noted for all medications in the drug class. An indication is defined as the identified, documented clinical rationale for administering a medication that is based upon a physician’s (or prescriber’s) assessment of the resident’s condition and therapeutic goals. This definition of indication will be included in the final version of the MDS RAI 3.0 v 1.18.11.
134	Supporting Documentation for Indication	If the physician orders an antibiotic to treat a urinary tract infection (UTI), but the infection does not meet the facilities evidence-based criteria (McGeer, NHSN, or Loeb) in the last 30 days, therefore the UTI is not coded on the MDS in Section I, does this physician documentation support the use of the antibiotic coded at N0415B2?	If the physician has specified an indication and it is an appropriate indication according to Appendix PP, the assessor should capture the medication in N0415. It is important that assessors address each item on the MDS independently, using the MDS RAI 3.0 v1.18.11 User's Manual guidance for that item or section only. They should not attempt to apply guidance from another item or section to determine coding. Additionally, they should seek guidance from the resident’s physician and, if needed, the pharmacist to determine the indications for each medication included in the resident’s medication regimen.

#	Topic	Question	Response
135	Supporting Documentation for Indication	If a resident, like the resident in example 4 in Examples of Inactive Diagnoses in Section I, has a physician documented diagnosis of schizophrenia and is receiving an antipsychotic medication, the instructions state that the diagnosis code cannot be coded at I6000 because of lack of supporting documentation. But since the documentation supports that schizophrenia is why the physician ordered the antipsychotic medication, would this documentation support the use of coding Column 2, Indication Noted, for N0415A2?	The example involving schizophrenia in the MDS RAI 3.0 v1.18.11 User's Manual provides a scenario in which coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required. In this scenario and others, nursing home teams should work with the resident's physician and, if needed, the pharmacist to determine the indications for each medication included in the resident's medication regimen. If the physician has specified an indication and it is an appropriate indication according to Appendix PP of the SOM, the assessor should capture the medication in N0415. It is important that assessors address each item on the MDS independently, using the MDS RAI 3.0 v1.18.11 User's Manual guidance for that item or section only. They should not attempt to apply guidance from another item or section to determine coding. Please note that CMS defines "indication for use" in the SOM, Appendix PP, Guidance to Surveyors for Long Term Care Facilities as "the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals." The SOM can be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf.
136	N0415E. Anticoagulants	N0415E. Anticoagulants, does this include anticoagulants used to flush an IV line?	Do not include flushes to keep an IV access port patent when coding N0415E. This will be added as a coding tip to the final version of the MDS RAI 3.0 v1.18.11 User's Manual.

Section O

#	Topic	Question	Response
137	High-Concentration Oxygen	For O0110C4, High-Concentration Oxygen, does CMS expect to see the calculation for fraction of inspired oxygen (FiO2), for confirmation when the concentration exceeds 40%? Or can CMS provide additional information, akin to the inclusion of exceeding 4 liters per minute per NC? Such as how many liters are required when simple face masks, partial and nonrebreather masks, face tents, venturi masks, aerosol masks, and high-flow cannula or masks are used.	Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual, states that the RAI process has multiple regulatory requirements regarding the assessment and documentation process. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining incompliance with the requirements of the Federal regulations and the instructions contained within this manual. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including to code the items in GG0130. Self-Care and GG0170. Mobility according to their facility policy and procedure and in compliance with any Federal and State requirements.

#	Topic	Question	Response
138	Oxygen Use	Will we be required to document time spent using oxygen (O2), to support the 14-hour time frame?	Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual, states that the RAI process has multiple regulatory requirements regarding the assessment and documentation process. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining incompliance with the requirements of the Federal regulations and the instructions contained within this manual. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including to code the items in GG0130. Self-Care and GG0170. Mobility according to their facility policy and procedure and in compliance with any Federal and State requirements. In addition, for a resident whose stay is covered by Medicare Part A, documentation must substantiate the resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.
139	Oxygen Therapy	If resident is on O2 at 2L/min for chronic obstructive pulmonary disease (COPD) and the order does not specifically state "hypoxemia," can you capture the O2 on the MDS in Section O?	Check all treatments, programs, and procedures that are part of the current care or treatment plan during those assessment periods. If the oxygen is part of the resident's current care or treatment plan regardless of reason for its use, O0110C1. Oxygen Therapy should be checked.

#	Topic	Question	Response
140	Oxygen Therapy	We were told by case mix if oxygen is administered for comfort (i.e., hospice) or isn't for hypoxia/COPD etc., we can't count it on the MDS. We have had it taken away by case mix.	According to the instructions for coding O0110C1, the assessor should code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. The interdisciplinary team should work with the physician to determine if oxygen for reasons such as comfort in conjunction with end-of-life care is delivered to relieve hypoxia.
141	Oxygen Therapy	How do we prove >/= 14 hours of O2 use? Nurses just mark yes or no.	While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. Please see Chapter 1, 1.3 Completion of the RAI, for further details.
142	High-Concentration Oxygen Therapy	Would we code vapotherm as high flow oxygen?	Code O0110C4. High-concentration if oxygen therapy was provided via a high-concentration delivery system. A high-concentration oxygen delivery system is one that delivers oxygen at a concentration that exceeds a fraction of inspired oxygen FiO2 of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow rate of 4 liters per minute). A high-concentration delivery system can include either high- or low-flow systems (e.g., simple face masks, partial and nonrebreather masks, face tents, venturi masks, aerosol masks, and high-flow cannula or masks). Providers should work with the resident's physician and the device vendor to determine if oxygen administration meets the definition of a delivery system operating under high concentration.

#	Topic	Question	Response
143	Oxygen Therapy	What documentation is required to chart continuous O2 once a shift, stating that resident is on continuous O2, or would it require monitoring throughout the shift stating it is on resident and has not been removed?	Assessors should follow facility established policies for documenting medication and treatment regimens. CMS does not impose specific documentation procedures on nursing homes in completing the RAI; however, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. Completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. Please see Chapter 1, 1.3 Completion of the RAI, for further details.
144	Oxygen Therapy	For O0110C1. Oxygen therapy, the guidance manual specifically states, to code oxygen administered via mask, cannula, etc., "delivered to a resident to relieve hypoxia." If there is no documentation of hypoxia, but the resident reported shortness of breath and the oxygen was used, can oxygen still be marked?	Check all treatments, programs, and procedures that are part of the current care/treatment plan during those assessment periods. If the oxygen is part of the resident's current care/treatment plan, regardless of the reason for its use, O0110C1. Oxygen Therapy should be checked. For the On Admission or At Discharge periods, apply the MDS RAI 3.0 v1.18.11 User's Manual's specific definitions in determining whether oxygen is coded as continuous (delivered for greater than/equal to 14 hours per day) or intermittent (oxygen was not delivered continuously for at least 14 hours per day).
145	Bilevel Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP)	Clarification on O0100G1. Non-invasive mechanical ventilator. Does a Trilogy Machine apply to either the BiPAP or CPAP?	For O0110G1. Non-invasive mechanical ventilator, you would check O0110G2. BiPAP or O0110G3. CPAP, depending on how the Trilogy machine is being used, i.e., as either a BiPAP or a CPAP.
146	Chemotherapy	Please clarify if chemo is used for non-cancer treatment, we do NOT check in Section O.	This instruction has not changed. A chemotherapy agent administered as an antineoplastic given by any route is coded in this item. However, each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment. For example, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation.

#	Topic	Question	Response
147	Chemotherapy	If a resident is receiving chemotherapy not related to cancer, how is this item coded (e.g., oral/injection chemotherapy for autoimmune diseases)?	As stated in the Coding Tips in the MDS RAI 3.0 v1.18.11 User's Manual for O0110A1. Chemotherapy: "Code any type of chemotherapy medication administered as an antineoplastic for cancer treatment given by any route in this item. Medications coded here are those actually used for cancer treatment. Each medication should be evaluated to determine its reason for use before coding it here."
148	Types of IV Access	Is a perma-cath a central line?	A perma-cath is a type of tunneled central venous catheter placed usually through the jugular vein into or near the right atrium. The assessor would capture this device in the appropriate column(s) as follows: O0110O1. IV Access and O0110O4. Central (e.g., peripherally inserted central catheter (PICC), tunneled, port).
149	Intravenous (IV) Flushes	Verifying whether you can code O011O1 if the IV is being flushed only.	Coding O0110O1. IV Access refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, TPN, or, in some instances, the measurement of central venous pressure. Any vein access is coded here as well as in the appropriate subitem. However, flushes to keep an IV access site patent or IV fluids without medications are not captured in O0110H1. IV medications.
150	IV Access	Would a quinton catheter (large bore central venous catheter used for dialysis placed in the jugular or femoral vein) be classified as a central line?	O01101O1. IV Access identifies a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, TPN, or in some instances the measurement of central venous pressure. When a resident has IV access (O0110O1) and that access is centrally located, check both O0110O1 and O0110O4. Central (e.g., PICC, tunneled, port).

#	Topic	Question	Response
151	IV Access	For items O0110O1. IV access and O0110O2. Peripheral, if a resident is admitted with peripheral IV access for seizure precautions or PRN use for hypertensive medications only (necessitating saline flushes), is it correct to code both O1. IV access and O2. peripheral?	Yes, O0110O1. IV Access refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, TPN, or in some instances the measurement of central venous pressure. When a resident has IV access, and that access is peripheral, check both O0110O1. IV Access and O0110O2. Peripheral, even if only accessed as needed for medication or for flushes to maintain patency. When coding O0110. Special Treatments, Procedures and Programs, the items are listed first as a broad description of a category describing a treatment, procedure, or program (parent-item) and are then followed by a more specific type of treatment, procedure, or program (child-item).
152	Hemodialysis	Does the catheter in the vein for hemodialysis count as IV access also?	O0110O1. IV Access, refers to a catheter inserted into a vein for a variety of clinical reasons, including: long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or, in some instances, the measurement of central venous pressure. If a resident receives hemodialysis, this should also be coded in O0110J2. Hemodialysis.
153	O0110. Special Treatments, Procedures, and Programs on Admission	If a resident receives IV medication in hospital the day of admission, which is day 1 of a Medicare skilled stay, can we take credit with an admission assessment on day 3?	When coding O0110, Column a, On Admission, check all treatments, procedures, and programs received by, performed on, or participated in by the resident on days 1-3 of the SNF PPS stay starting with A2400B. This would not include any treatments, procedures, or programs in the hospital even if they occurred on the same day the resident was admitted into the facility.
154	O0110. Special Treatments, Procedures, and Programs	I had a question regarding IV medications. They have taken the wording out "in the last 14 days," so for IV meds to be counted, is it now going to be only in the facility, or if they received an IV medication on the day they left the hospital, does that count?	For the new column, a, On Admission, you will only check all treatments, procedures, and programs received by, performed on, or participated in by the resident on days 1-3 of the SNF PPS Stay starting with A2400B. The language regarding 14 days for Column b, While a Resident, still exists. Check all treatments, procedures, and programs that the resident received or performed after admission/entry or reentry to the facility and within the last 14 days. If no treatments, procedures, or programs were received by, performed on, or participated in by the resident within the last 14 days or since admission/entry or reentry, check Z, None of the above.

#	Topic	Question	Response
155	O0110. Special Treatments, Procedures, and Programs	Please confirm, O0110A and O0110C are only for 5-day and Nursing Home Part A PPS Discharge (NPE) MDS?	Yes, as noted in Chapter 3, Section O, the coding instructions for O0110, Column a, On Admission, and Column c, At Discharge, specifically state days 1-3 of the SNF PPS stay starting with A2400B, and the last 3 days of the SNF PPS stay ending with A2400C.
156	O0110. Special Treatments, Procedures, and Programs	The Coding Tips for A2300 reference to O0600, Physician Examinations, has been removed from the item sets.	CMS has replaced the reference to O0600 in the final version of the MDS RAI 3.0 v1.18.11 User's Manual.

Section Q

#	Topic	Question	Response
157	Legal Guardian and Legally Authorized Representative	What is the difference between “legal guardian” and “legally authorized representative”?	According to the definition in Section Q, a guardian/legally authorized representative is a person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment. As stated in Appendix PP of the SOM for Long Term Care Facilities, a resident may have a representative that has been appointed legally under State law through, for example, a power of attorney, guardian, limited guardian, or conservatorship. These legal appointments vary in the degree that they empower the appointed representative to make decisions on behalf of the resident. The individual arrangements for legal representation will have to be reviewed to determine the scope of authority of the representative on behalf of the resident. The SOM can be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf.