MDS 3.0 RAI User's Manual (v1.16R) Errata (v1.1)

Effective February 13, 2019

Issue ID	Issue	Resolution
1	In Chapter 3, page J-5, coding tip #2 conflicts with the Assessment Submission and Processing (ASAP) edits -3784 and -3788. Coding tip #2 was added to the RAI Manual and effective 10/01/2018. The coding tip is as follows: If the resident interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items J0300–J0600. Item J0700, Should the Staff Assessment for Pain be Conducted, is coded 0, No. Edit -3784 is as follows: Skip patterns based on J0200: a) If J0200= [0], then the following rules apply: ---a1) All active items from J0300 through J0700 must equal [^]. ---a2) If J0800A through J0800Z are active, they must not equal [^]. b) If J0200= [1], then if J0300 is active it must not equal [^]. c) If J0200=	Edits -3784 and -3788 will be enhanced to allow providers to submit a dash in items J0300–J0600 and submission of a "0" (No) in item J0700 when a resident interview should have been conducted (J0200 = 1) but was not done within the look-back period of the ARD. The enhanced edits will be effective with the October 1, 2019 ASAP system release. Until the time that the ASAP system is enhanced to support the coding directive, providers should continue to code J0200 as 1, Yes and enter the standard "no information" code (a dash "-") in the resident interview items J0300–J0600 if the resident interview should have been conducted but the interview was not done within the look-back period. In this case, providers should also enter the standard "no information" code (a dash "-") in item J0700, Should the Staff Assessment for Pain be Conducted?, and in the Staff Assessment for Pain items J0800 and J0850.

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	[-], then all active items from J0300 through J0700 must equal [-]. Edit -3788 is as follows: Consistency rules for J0700: a) If J0400= [1,2,3,4], then if J0700 is active it must equal [0]. b) If J0400= [9,-], then if J0700 is active it must equal [1,-]. As currently written, edits -3784 and -3788 will not allow providers to submit the values in items J0200–J0700 as identified in the coding tip above.	
2	In Chapter 3, page J-5, under "Steps for Assessment" in J0200: Should Pain Assessment Interview Be Conducted?, the skip pattern reference in the second step needed to be corrected.	In Chapter 3, page J-5, under "Steps for Assessment" in J0200: Should Pain Assessment Interview Be Conducted?, the skip pattern reference in the second step has been corrected: 2. Determine whether or not the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely/never understood, skip to item ~~J1100, Shortness of Breath~~J0800, Indicators of Pain or Possible Pain.

Effective October 1, 2018

Issue ID	Issue	Resolution
1	In Chapter 3, page J-36, under "Coding Tips" in J2000: Prior Surgery, the criteria for major surgery needed to be modified to remove the requirement for general anesthesia.	In Chapter 3, page J-36, under "Coding Tips" in J2000: Prior Surgery, the word "all" has been deleted: • Generally, major surgery for item J2000 refers to a procedure that meets ~~all~~ the following criteria:
2	In Chapter 3, page J-36, under "Coding Tips" in J2000: Prior Surgery, the criteria for major surgery needed to be modified to remove the requirement for general anesthesia.	In Chapter 3, page J-36, under "Coding Tips" in J2000: Prior Surgery, criterion 2 has been deleted, and criterion 3 renumbered to 2. – ~~2. the resident had general anesthesia during the procedure,~~ **and** – ~~3.~~ 2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.
3	In Chapter 3, page J-36, Example 1, in J2000: Prior Surgery, the rationale for the example needed to be modified to remove the reference to general anesthesia.	In Chapter 3, page J-36, Example 1, in J2000: Prior Surgery, the rationale has been updated to remove the reference to general anesthesia. Rationale: Mrs. T's skin tag removal surgery did not require an acute care inpatient stay~~, and general anesthesia was not administered~~; therefore, the skin tag removal does not meet ~~all three~~ the required criteria to be coded as major surgery. Mrs. T did not have any other surgeries in the last 100 days.

Issue ID	Issue	Resolution
4	In Chapter 3, page J-37, Example 2, in J2000: Prior Surgery, the rationale for the example needed to be modified to remove the reference to general anesthesia.	In Chapter 3, page J-37, Example 2, in J2000: Prior Surgery, the rationale has been updated to remove the reference to general anesthesia. Rationale: Bowel resection is a major surgery ~~requiring general anesthesia and~~ that has some degree of risk for death or severe disability, and Mr. A required a five-day hospitalization. However, the bowel resection did not occur in the last 100 days; it happened six months ago, and Mr. A has not undergone any surgery since that time.
5	In Chapter 3, page J-37, Example 3, in J2000: Prior Surgery, the example needed to be modified to remove the reference to general anesthesia.	In Chapter 3, page J-37, Example 3, in J2000: Prior Surgery, has been updated to remove the reference to general anesthesia. 3. Mrs. G was admitted to the facility for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy ~~for which she received general anesthesia~~. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record. She was transferred to the facility immediately following a four-day acute care hospital stay.

Issue ID	Issue	Resolution
6	In Chapter 3, page J-37, Example 3, in J2000: Prior Surgery, the rationale for the example needed to be modified to remove the reference to general anesthesia.	In Chapter 3, page J-37, Example 3, in J2000: Prior Surgery, the example rationale has been updated to remove the reference to general anesthesia. Rationale: In the last 100 days, Mrs. G underwent a complicated cholecystectomy, ~~for which she required general anesthesia,~~ which required a four-day hospitalization. She additionally had comorbid diagnoses of diabetes, morbid obesity, and anxiety contributing some additional degree of risk for death or severe disability. ~~Mrs. G required a four-day hospitalization that occurred in the last 100 days.~~

J0200: Should Pain Assessment Interview Be Conducted? (cont.)

2. Determine whether or not the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely/never understood, skip to item *J0800, Indicators of Pain or Possible Pain*.
3. Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

*Attempt to complete the interview if the resident is at least sometimes understood and an **interpreter is present** or not required.*

- `Code 0, no`: if the resident is rarely/never understood or an interpreter is required but not available. Skip to **Indicators of Pain or Possible Pain** item (J0800).
- `Code 1, yes`: if the resident is at least sometimes understood and an interpreter is present or not required. Continue to **Pain Presence** item (J0300).

Coding Tips and Special Populations

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items J0300–J0600. Item J0700, Should the Staff Assessment for Pain be Conducted, is coded 0, No.
- Do not complete the Staff Assessment for Pain items (J0800–J0850) if the resident interview should have been conducted, but was not done.
- If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate interview not attempted and complete **Staff Assessment of Pain** item (J0800), instead of the **Pain Interview** items (J0300-J0600).
- There is one exception to completing the Staff Assessment for Pain items (J0800–J0850) in place of the resident interview. This exception is specific to a stand-alone, unscheduled Prospective Payment System (PPS) assessment only and is discussed on page 2-60. For this type of assessment only, the resident interview may be conducted up to two calendar days after the ARD.
- When coding a stand-alone Change of Therapy OMRA (COT), a stand-alone End of Therapy OMRA (EOT), or a stand-alone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) was obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.

J2000: Prior Surgery (cont.)

Steps for Assessment

1. Ask the resident and his or her family or significant other about any surgical procedures in the 100 days prior to admission.
2. Review the resident's medical record to determine whether the resident had major surgery during the 100 days prior to admission.

   Medical record sources include medical records received from facilities where the resident received health care during the previous 100 days, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Coding Instructions

- Code 0, No, if the resident did not have major surgery during the 100 days prior to admission.
- Code 1, Yes, if the resident had major surgery during the 100 days prior to admission.
- Code 8, Unknown, if it is unknown or cannot be determined whether the resident had major surgery during the 100 days prior to admission.

Coding Tips

- Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:
  1. the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF), ***and***
  2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Examples

1. Mrs. T reports that she required surgical removal of a skin tag from her neck a month and a half ago. She had the procedure as an outpatient. Mrs. T reports no other surgeries in the last 100 days.

   Coding: J2000 would be coded 0, No.

   Rationale: Mrs. T's skin tag removal surgery did not require an acute care inpatient stay; therefore, the skin tag removal does not meet *the* required criteria to be coded as major surgery. Mrs. T did not have any other surgeries in the last 100 days.

J2000: Prior Surgery (cont.)

2. Mr. A's wife informs his nurse that six months ago he was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis. Mr. A's wife reports Mr. A has had no other surgeries since the time of his bowel resection.

   Coding: J2000 would be coded 0, No.

   Rationale: Bowel resection is a major surgery *that* has some degree of risk for death or severe disability, *and* Mr. A required a five-day hospitalization. However, the bowel resection did not occur in the last 100 days; it happened six months ago, and Mr. A has not undergone any surgery since that time.

3. Mrs. G was admitted to the facility for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record. She was transferred to the facility immediately following a four-day acute care hospital stay.

   Coding: J2000 would be coded 1, Yes.

   Rationale: *In the last 100 days,* Mrs. G underwent a complicated cholecystectomy, *which required a four-day hospitalization*. She additionally had comorbid diagnoses of diabetes, morbid obesity, and anxiety contributing some additional degree of risk for death or severe disability.