

MDS 3.0 RAI MANUAL V1.08 AND CHANGES TO ITEM SETS EFFECTIVE 4/1/2012

This is not an all inclusive listing of the changes. Refer to CMS Website for Complete Information
http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

Overall

- Manual pages
 - Only pages with actual changes have updated footer “April 2012
 - Pages without changes have footer “October, 2011”
 - Screen shots changed to match Item Set (Form)
- Term “Mental Retardation (MR)” changed to “Intellectual Disability (ID)”
 - Corrections to Appendix C, CAAs 2,7, &12 will have terms “Mental retardation/development disability” replaced with “Intellectual disability/developmental disability in 2012 Fall Update
- Text/label changed to be consistent throughout the assessment instrument
 - Admission/Reentry changed to Admission/Entry or Reentry
 - A0310, A1600, M0300, M0800, J1700, J1800, J1900
 - OBRA, PPS, or Discharge to OBRA or Scheduled PPS
 - M0800, M0900, J1800, J1900
- A0310G. Type of Record. Planned or Unplanned Discharge. – *New Item*
 - The following information was provided from CMS. It is not in the manual.
 - Unplanned Discharge includes:
 - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine whether an acute-care admission is required based on emergency department evaluation; OR
 - Resident unexpectedly leaving the facility against medical advice; OR
 - Resident unexpectedly deciding to go home or to another setting
 - Planned discharge is any discharge that does not fit the above definition.
- Review carefully Discharge Assessment Item Set Version 1.10.4 Effective 04/01/2012 for :
 - Additions and Deletions.
 - Skip Patterns allowed for Unplanned Discharges - Information on Discharge Assessment Item Set
 - Section C. Cognitive Patterns. BIMS C0100-C0600
 - Section D. Mood
 - Section J. Health Conditions. Pain Interview J0200- 0600
 - Section K. Swallowing and Nutritional Status. Item K0510. Nutritional Approach C. Mechanically altered diet; D. Therapeutic diet; Z. None of the Above
- Make every effort to complete resident interviews for each resident
 - Only residents who definitely are not interviewable are residents who are comatose
 - Failure to interview residents who are interviewable can result in a citation for an inaccurate assessment.
- The following information was provided by CMS. It is not in the manual. It must be followed.
 - Interview on Unscheduled Assessment - When coding a standalone unscheduled PPS assessment (COT, EOT, SOT), the resident interview items may be coded using the responses provided by the resident on the previous unscheduled or scheduled assessment, **IF**:
 - The time period of the date of the interview on the previous assessment (Z0400) to the required date of the interview on the current assessment(Z0400) is 14 days or fewer **AND**

- The same individual who conducted the original interview signs the subsequent assessment (Z0400) that has the same carryover interview responses along with the date of the original interview.
- If the individual that performed the original interview is not available to carry over the interview responses and sign Z0400, then the interview cannot be carried forward.
- Only interviews that meet the 14 or fewer day criteria can be carried forward even if they were done in the same prior assessment.

Chapter 3

- **Section A. Identification Information Item Set Changes**
 - A0050. Type of Record. *New Item*. It replaces X0100. Type of Record
 - A310A & B. Type of Assessment. Changed wording of code option 99. to “None of the Above”
 - A0310G. Type of Record. Planned or Unplanned Discharge. *New Item*
 - A1500. PASRR. Changed Mental Retardation to Intellectual Disability – Completed for all OBRA Comprehensive Assessments. Review option choices and skip pattern.
 - A1510. Level II PASRR Conditions – *New Item*
 - A1800. Entered From & A2100. Discharged To. *New coding option* “09. Long Term Care Hospital”
- **Section B. Hearing, Speech, and Vision**
 - Discharge Assessment – only complete B0100. Comatose
- **Section C. Cognitive Patterns**
 - Discharge Assessment – Deletion: C0800. Long Term Memory, C0900. Memory Recall
- **Section E. Behavior**
 - E0100. Indicators of Psychosis. Label changed to “Potential” Indicators of Psychosis.
 - Discharge Assessment
 - Addition: E0200. Behavioral Symptoms; E0800. Rejection of Care; and E0900. Wandering
- **Section G. Functional Status**
 - G0110. ADL’s - Definition of Code “8” changed to “ADL activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7 day period.” Similar language added to the Algorithm, Rule of 3; G0110. Coding Tips and Special Populations; G120. Bathing
 - G0300. Balance During Transitions and Walking. Changed coding option language from “human” assistance to “staff” assistance.
 - G0300E. Surface to Surface Transfer. Added “chair” (transfers between bed and “chair” or wheelchair.)
 - Discharge Assessment
 - Deletion: G0110. ADLs 2. Support; G0300. Balance; G0400. ROM; G0600. Mobility Devices
- **Section I. Active Diagnosis**
 - Coded diseases must have *direct* relationship to resident’s *current* status
 - I4800. Non-Alzheimer’s Dementia - Label Change
 - Discharge Assessment – Deletion: Many diagnoses
- **Section J. Health Conditions**
 - J0100B. Received PRN medications OR “was offered and declined” was added to question on Item Set. This has always been in the manual.
 - Discharge Assessment
 - Deletion
 - J0700. Should Staff Assessment for Pain be Conducted?
 - J0800 and J0850 Staff Assessment
 - Addition: J1550. D. Internal Bleeding
 - J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is most recent and J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent. This is a change in the MDS Types used to code these items

- Do not compare to Discharge Assessment, or any OMRA Assessments (COT, SOT, EOT) when coding these items.
- **Section K. Swallowing & Nutritional Status**
 - K0310. Weight Gain *New Item*
 - Replaced K0500. Nutritional Approaches with K0510. Nutritional Approaches
 - K0510. Nutritional Approaches. Coding is 2 column approach to capture “while a resident” & “while not a resident” information *New Item*
- **Section M. Skin Conditions**
 - M0700. Most Severe Tissue Type for Any Pressure Ulcer, *New Option* “9. “None of the Above”
 - M0800. Worsening in PU Status Since Prior Assessment changed to Worsening in PU since Prior Assessment (OBRA or Scheduled PPS) or last admission/entry or reentry and M0900 Healed PU. A. Were PU present on Prior Assessment (OBRA or Scheduled PPS) This is a change in the MDS Types used to code these items.
 - Do not compare to Discharge Assessment, or any OMRA Assessments (COT, SOT, EOT) when coding these items.
 - M0900. Healed PU. *New Option* “9. None of the above.
 - M1040. Other Ulcers, Wounds & Skin Problems additions:
 - G. Skin Tears *New Item*
 - H. Moisture Associated Skin Damage (MASD), i.e. incontinence, perspiration, drainage *New Item*
 - M1200. Skin and Ulcer Treatments. E. Ulcer Care changed to Pressure Ulcer Care
 - Discharge Assessment – Many items deleted
- **Section N. Medications**
 - N0400. Medications Received replaced with N0410. Medications Received
 - N0410. Record the number of days the following medications was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) *New Item*
 - Antipsychotic.
 - Antianxiety:
 - Antidepressant
 - Hypnotic
 - Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)
 - Antibiotic
 - Diuretic
 - Discharge Assessment – Addition Anticoagulant, Antibiotic, and Diuretic
- **Section O. Special Treatments, Procedures, and Programs**
 - Discharge Assessment
 - Deletion
 - O0100. E. Tracheostomy Care; F. Ventilator or respirator; M. Isolation
 - O0600. Physician Examinations
 - O0700. Physician Orders
 - Addition
 - O0400 Therapies. 4. Days of Therapy; 5. Therapy Start Date; 6. Therapy End Date
 - O0250. Influenza. Additional information provided to assist in determination of flu season, including a chart and local health department.
 - O0600. Physical Examinations. And O0700. Physician Orders. Deletion in Coding Tips is “exclusion of PAs, NPs, and CNS employed by the facility”.
- **Section Q. Participation in Assessment & Goal Setting Item Set Changes**
 - Review carefully, may revisions.
 - Q0300. Resident’s Overall Expectations. Information added including, “In some guardianship situations, the decision-making authority regarding individual’s care is vested in the guardian. But this should not create a presumption that the resident is not able to comprehend or communicate their wishes.”

- Q0400. Is active discharge plan already “*occurring*” for the resident to return to the community? Focuses that the process of discharge planning taking place and not just documented. Don’t assume a resident can’t be discharged, even those with Alzheimer’s. Refer to Local Contact Agency (LCA) allows residents to learn of community options. NF social workers/staff members remain active in discharge process even if referral to LCA is made.
- Deletion
 - Q0400B. What determination was made by the resident & the care planning team regarding discharge to the community?
 - Q0500A. Has resident been asked about returning to the community
- Addition
 - Q0490. Does the resident’s clinical record document a request that this question be asked only on comprehensive assessments? Resident’s preference to avoid being asked Question Q0500B. Return to Community on OBRA non-comprehensive assessments.
 - Q0550. Does the resident (or family or significant other or guardian, if resident unable to respond) want to be asked about returning to the community on all assessments?
- Q0600. Referral. Change in wording of answers and instructions
- **Section Correction**
 - Deletion X0100. Type of Record. It is replaced by A0050. Type of Record

Chapter 4

- Change in CAT Logic Table
 - Urinary Incontinence and Indwelling Catheter
 - Mood State
 - Nutrition
 - Feeding Tube
 - Psychotropic Medication Use
 - Return to Community Referral
- Return to Community Referral – Additional information on responsibilities of nursing home staff and local contact agency

Chapter 5. CMS emphasis on Inactivation Process.

An inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. This includes the following:

- Type of Provider (Item A0200)
- Type of Assessment (A0310)
- Entry Date (Item A1600) on an Entry tracking record
- Discharge Date (Item A2000) on a Discharge/Death in Facility record
- Assessment Reference Date (A2300) on an OBRA or PPS assessment.

When the provider determines that an event date is inaccurate the provider must inactivate the (MDS) record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct event date or type of assessment, ensuring that the clinical information is accurate. (Page 5-12.)” CMS further emphasized MDS Coordinators must remember the ARD of the new assessment must be set on the date **the error is determined or later, but not earlier.**

It is critical the MDS Coordinator review all MDS assessment very carefully prior to submission to avoid errors that would result in inactivation of an assessment. Having to submit a new assessment that will likely have an ARD that is not compliant with the assessment schedule and will result in a late or missed assessment. (Chapter 2 Pages 71-72).

Chapter 6 Refer to Change table for revisions.