



MDS Changes are Coming

Are you ready for October 1, 2024?

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Quality
Insights

QIN-QIO

Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Helpful Links

- **MDS FORMS AND RAI MANUAL**

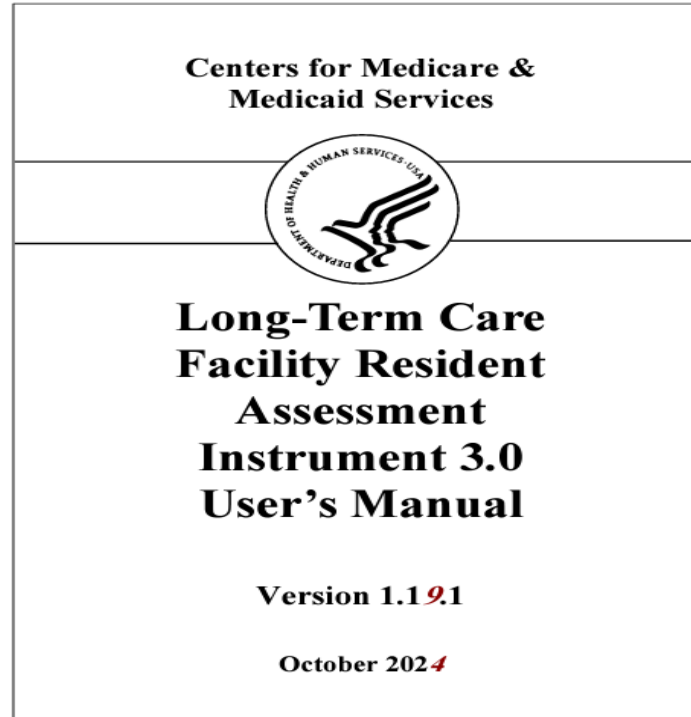
- <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/mds30raimanual>
- <https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf>

- **CMS Official YouTube Channel**

- <https://www.youtube.com/cmshhsgov>



Are you using the correct RAI version?



Where are the changes?

Revisions to Chapter Guidance:

- Chapter 2
- Chapter 5

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

- Section A
- Section C
- Section GG
- Section H
- Section I
- Section K
- Section N
- Section O
- Section X



Section A: Identification Information



A2121 & A2122



Provision of Current Reconciled Medication List to Subsequent Provider at Discharge & Route of Current Reconciled Medication List Transmission to Subsequent Provider

REMOVED from the Part A PPS Discharge (NPE) Assessment



Section C

C0500: BIMS Summary Score





C0500 – BIMS Summary Score Coding Tips

- Occasionally, a resident can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, BIMS Summary Score, and complete the Staff Assessment for Mental Status.
- If all of the BIMS items are coded with a dash, then C0500, BIMS Summary Score must also be coded with a dash.



Section GG: Functional Abilities



Columns GG: Discharge Goals

Column 2 from GG0130 and GG0170

REMOVED



GG0130: Self-Care Examples updated

Resident J *completed all hygiene tasks independently two out of six times during the observation period. The other four times they were unable to complete brushing and styling their hair and washing and drying their face because of elbow pain after initiating the tasks, so a staff member completed these tasks.*

Coding: GG0130I would be coded 02, Substantial/*maximal* assistance.

Rationale: *Although Resident J was able to complete their personal hygiene tasks independently on two of the six occasions the activity occurred, a staff member had to complete their personal hygiene tasks after the resident initiated them on four of the six occasions. Because the staff had to complete Resident J's personal hygiene tasks on four of the six occasions the activity occurred during the observation period, the staff provided more than half the effort to complete the personal hygiene tasks.*



GG0170N, 4 steps; and GG00170O, 12 steps

Coding Tips

- If, at the time of the assessment, a resident is unable to complete the activity because of a physician-prescribed restriction of no stair climbing, they may be able to complete the stair activities safely by some other 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.



GG0170N, 4 steps; and GG00170O, 12 steps

Coding Tips



If, at the time of assessment, a resident is unable to complete the stair activities because of a physician-prescribed bedrest, code the stair activity using the appropriate “activity not attempted” code.

If the activity was not attempted, code reason:

07 – Resident refused

09 – Not applicable – Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury

10 – Not attempted due to environmental limitations

88 – Not attempted due to medical condition or safety concerns

GG0170N, 4 steps; and GG00170O, 12 steps

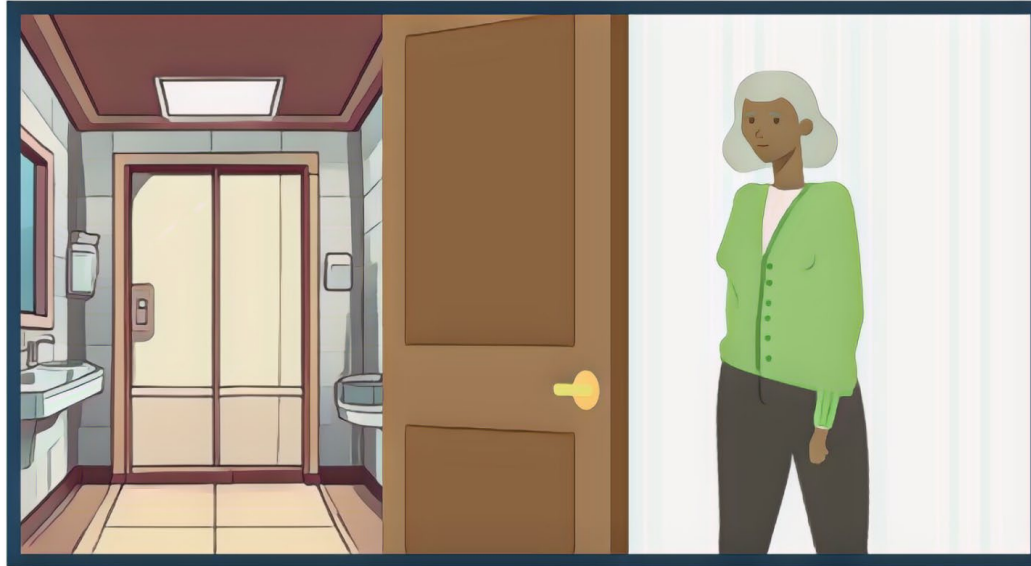
Coding Tips



While a resident may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means, without taking more than a brief rest break to consider the stair activity completed.



Section H: Bladder and Bowel



H0100B – External Catheter

Updated definition

Device attached to the shaft of the penis like a condom, **a female external catheter, or other non-invasive urine output management device or system that routes urine** to a drainage bag



Section I: Active Diagnoses



I2100: Septicemia



Item I2100 Septicemia:

*For sepsis to be considered septicemia, there needs to be inflammation due to sepsis and evidence of a microbial process. If the medical record reflects inflammation due to sepsis and evidence of a microbial process, code I2100, Septicemia. If the medical record does **not** reflect inflammation due to sepsis and evidence of a microbial process, enter the sepsis diagnosis and ICD Code in item I8000, Additional Active Diagnoses.*

Item I2300: Urinary Tract Infection (UTI)

Reminder

The UTI has a look-back period of 30 days for active disease instead of 7 days.

Code only if both of the following are met in the last 30-days:

1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,
AND
2. A physician documented UTID diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.



Additional Resources

SBAR toolkit from Quality Insights

<https://www.qualityinsights.org/qin/resources#sbar-toolkit-fillable-forms>

SBAR — Sepsis
Complete this form before contacting the resident's physician.
Date/Time: _____
Resident Name: _____
Nurse: _____
I am contacting you about a suspected sepsis because:
Vital Signs: BP _____ / _____
 No Yes Deviation from baseline:
Admission Date: _____
 No Yes Current infection:
 No Yes Started treatment:
 No Yes Resident has a fever:
Resident presents with infection (SIRS) criteria.
 No Yes Temperature: _____
 No Yes Heart rate > 100:
 No Yes Respiratory rate:
Results of recent labs (drawn within 24 hours):
WBC: _____ Creatinine: _____
INR or PTT: _____
Physician's Signature: _____
RESOURCE: Minnesota Hospital Association <https://www.mnha.org/Portals/0/documents/SBAR%20Toolkit%20Form%20-%202016.pdf>
Quality Insights

SBAR — Congestive Heart Failure (CHF)
Complete this form before contacting the resident's physician.
Physician Name: _____
Resident Name: _____
Nurse: _____
I am contacting you about a suspected CHF because:
VITAL SIGNS: BP _____ / _____
Recent Abnormal Labs: CBC: _____
Recent Chest X-Ray: Date: _____
Code Status: _____
Active Diagnoses: _____
 No Yes Resident has CHF within the last 24 hours:
 No Yes Resident has edema:
 No Yes Resident has rales:
 No Yes Diagnosis of CHF:
 No Yes Resident has a history of CHF:
Physical
 No Yes Edema present:
 No Yes Weight change:
 No Yes Cough present:
 No Yes Abnormal lung sounds:
 No Yes Abnormal hematuria:
 No Yes Diaphoretic:
 No Yes Cyanotic:
Other: _____
Physician's Signature: _____
SOURCES: 1. National Heart Lung and Blood Institute <https://www.nhlbi.nih.gov/health-topics/congestive-heart-failure>
2. Cardiovascular Nursing <https://www.education.com/nursing/conditions/congestive-heart-failure>
Quality Insights

SBAR — Post-Fall Huddle
Within 15-30 minutes of a fall, complete the following questions:
Date/Time of Fall: _____
Staffing:
 Staffed according to standard:
 Shift not staffed according to standard:
 Some staff unavailable due to other duties:
Where did the fall occur?
 Patient room Patient hallway
What do we think patient was doing?
 Getting up on own to go to bathroom:
 Reaching for something:
 Leaning on something:
 Other: _____
When was the patient last seen?
 No Yes Edema present:
 No Yes Weight change:
 No Yes Cough present:
 No Yes Abnormal lung sounds:
 No Yes Abnormal hematuria:
 No Yes Diaphoretic:
 No Yes Cyanotic:
Other: _____
Physician's Signature: _____
SOURCES: 1. National Heart Lung and Blood Institute <https://www.nhlbi.nih.gov/health-topics/congestive-heart-failure>
2. Cardiovascular Nursing <https://www.education.com/nursing/conditions/congestive-heart-failure>
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SBAR — Suspected IRI
Complete this form before contacting the resident's physician.
Date/Time: _____
Resident Name: _____
Nurse: _____
I am contacting you about a suspected IRI because:
Vital Signs BP _____ / _____
HR _____
Resp. rate _____
Temp. _____
Active diagnoses:
 No Yes Resident has pulmonary edema:
 No Yes Resident has a history of IRI:
 No Yes Current IRI:
 No Yes Resident uses a prosthetic limb:
Resident with a fever of 100.0 or one of the following:
 No Yes Respiratory rate > 20 per minute:
 No Yes New or worse:
 No Yes New or increased Sat s94% in O2 Sat of 3:
Afebrile resident with COPD:
 No Yes New or increased sputum color:
* For residents who regularly use a temperature of 2°F (1°C) definition of a fever.
Physician's signature: _____
SOURCES: 1. AHRQ, "Suspected UTI SBAR Toolkit" <https://www.ahrq.gov/nhsr/pdq/sbar-toolkit/define-whether-to-bring-toolkit-suspected-uti-sbar.html>
2. Stone, Nimala D., et al. "Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGee Criteria." <https://www.pain.org/abstract/10.1056/667743>
Quality Insights

SBAR — Suspected UTI
Complete this form before contacting the resident's physician.
Date/Time: _____
Resident Name: _____ Date of Birth: _____
Nurse: _____ Phone: _____
I am contacting you about a suspected UTI for the above resident.
Vital Signs BP _____ / _____ HR _____ Resp. rate _____ Temp. _____
Active diagnoses:
 No Yes Resident has an indwelling catheter:
 No Yes Resident is on dialysis:
 No Yes Resident is incontinent. If yes, new/worsening? No Yes:
 No Yes Advance directives. Specify: _____
 No Yes Resident has medication allergies. Specify: _____
 No Yes Resident is on an anticoagulant. Specify: _____
ASSESSMENT
Resident WITH indwelling catheter.
If one of the situations below is selected Yes, the criteria are met to initiate antibiotics.
 No Yes Fever of 100°F (38°C) or repeated temperatures of 99°F (37°C)*
 No Yes New back or flank pain
 No Yes Acute pain
 No Yes Rigors / shaking chills
 No Yes New dramatic change in mental status
 No Yes Hypotension (significant change from baseline BP or a systolic BP <90)
* For residents who regularly run a lower temperature, use a temperature of 2°F (1°C) above the baseline as a definition of a fever.
Resident WITHOUT indwelling catheter
If one of the three situations below is selected Yes, the criteria are met to initiate antibiotics.
 No Yes 1. Acute dysuria alone
 No Yes 2. Single temperature of 100°F (38°C) AND at least one new or worsening of the following: Urgency; Frequency; Back or flank pain; Suprapubic pain; Gross Hematuria; Urinary incontinence
 No Yes 3. No fever, but two or more of the following: Urgency; Frequency; Incontinence; Suprapubic pain; Gross hematuria
REQUEST FOR ORDERS
Physician's signature: _____ Date: _____
SOURCES: 1. AHRQ, "Suspected UTI SBAR Toolkit" <https://www.ahrq.gov/nhsr/pdq/sbar-toolkit/define-whether-to-bring-toolkit-suspected-uti-sbar.html>
2. Stone, Nimala D., et al. "Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGee Criteria." <https://www.pain.org/abstract/10.1056/667743>
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Section K: Swallowing/Nutritional Status



K0520: Nutritional Approaches

K0520B: Feeding Tubes

Feeding Tube definition

Presence of any type of tube that can deliver food/nutritional substances/fluids directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.

Removed Delivery of Medications from definition



Section N: Medications



N0415: High-Risk Drug Classes: Use and Indication

- A. Antipsychotic
- B. Antianxiety
- C. Antidepressant
- D. Hypnotic
- E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)
- F. Antibiotic
- G. Diuretic
- H. Opioid
- I. Antiplatelet
- J. Hypoglycemic (including insulin)
- K. Anticonvulsant
- Z. None of the above



Section O: Special Treatments, Procedures, and Programs



0011001 – IV Access

Code IV access, which refers to a catheter inserted into a vein for a variety of clinic reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parental nutrition (TPN), or, in some instances, the measurement of central venous pressure. **An arteriovenous (AV) fistula does not meet the definition of IV access of 0011001.**



O0300: Pneumococcal Vaccine

- Examples in the RAI were updated to reflect current up-to-date definitions
- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at:

<https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccinetiming.pdf>

- “Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
- For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at:

<https://www.cdc.gov/vaccines/schedules/hcp/index.html>

<http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

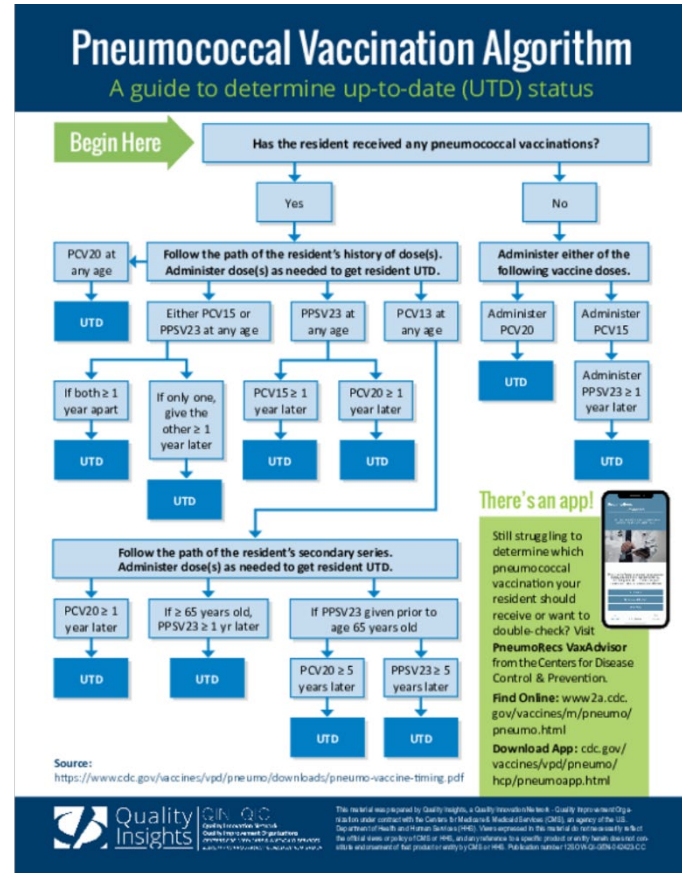
<https://www.cdc.gov/pneumococcal/vaccination.html>



Additional tools/resources

Pneumococcal Decision Tree from Quality Insights:

<https://www.qualityinsights.org/qin/resources#pneumococcal-vaccination-algorithm>



O0350: Resident's COVID-19 vaccination is up to date



O0350. Resident's COVID-19 vaccination is up to date

Enter Code

- 0. No, resident is not up to date
- 1. Yes, resident is up to date

- For the definition of “up to date,” providers should refer to the CDC webpage “Stay Up to Date with COVID-19 Vaccines” at: <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay>
- A dash is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence.

Coding Instructions

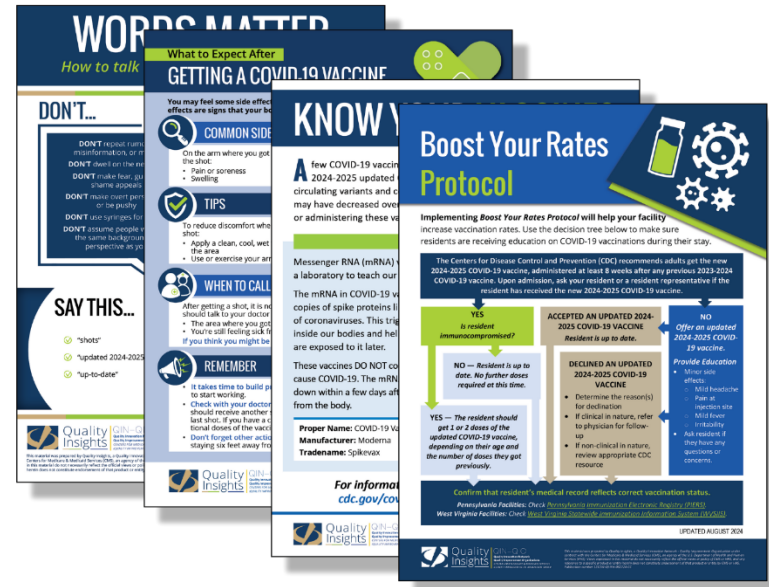
- Code 0, No, resident is not up to date if the resident does not meet the CDC's definition of up to date.
 - This includes residents who have not received one or more recommended COVID-19 vaccine doses for any reason, including medical, religious, or other qualified exemptions.
 - This includes resident for whom vaccination status cannot be determined.
- Code 1, Yes, resident is up to date if the resident meets the CDC's definition of up to date.
- A dash is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence.



Additional Tools/Resources

UPDATED COVID TOOLKIT from Quality Insights:

[https://www.qualityinsights.org/
qin/resources# covid-toolkit](https://www.qualityinsights.org/qin/resources# covid-toolkit)



PA State Specific Immunization Registry

PA Immunization Registry

PIERS (Pennsylvania Immunization Electronic
Registration System)

[https://www.pa.gov/en/agencies/health/healthcare-
and-public-health-professionals/piers.html](https://www.pa.gov/en/agencies/health/healthcare-and-public-health-professionals/piers.html)



WV State Specific Immunization Registry

WV Immunization registry

WVSIIS (West Virginia Statewide Immunization
Information System)

<https://www.wvimm.org/wvsiis/>



Section X: Correction Request



A Manual Deletion Request is required only in the following **four** cases:

1. Item A0410 Submission Requirement is incorrect
2. Record was submitted for the wrong facility
3. **Record Submitted was not for OBRA or Medicare Part A purposes**
4. Inappropriate submission of a test record as a production record



From Chapter 5 – further clarification

- When a facility erroneously submits a record that was not for OBRA or Medicare Part A purposes, CMS does not have the authority to collect the data contained in the record. An inactivation request will not fix the problem, since it will leave the erroneously submitted record in the history file, that is, the CMS database. A manual deletion is necessary to completely remove the erroneously submitted record and associated information from the CMS database.
- In instances in which an erroneous PPS assessment is combined with an OBRA-required assessment, if the item set code does not change, then a modification can be completed. If the item set code does change as a result of a modification, the provider must complete an MDS 3.0 Manual Assessment Correction/Deletion Request. This action will completely remove the assessment from the database. As indicated, the provider would complete and submit a new, stand-alone OBRA assessment.



Questions



Contact Us



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Resources

- <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/mds30raimanual>
- <https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf>

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