MDS Changes are Coming

Are you ready for October 1, 2024?

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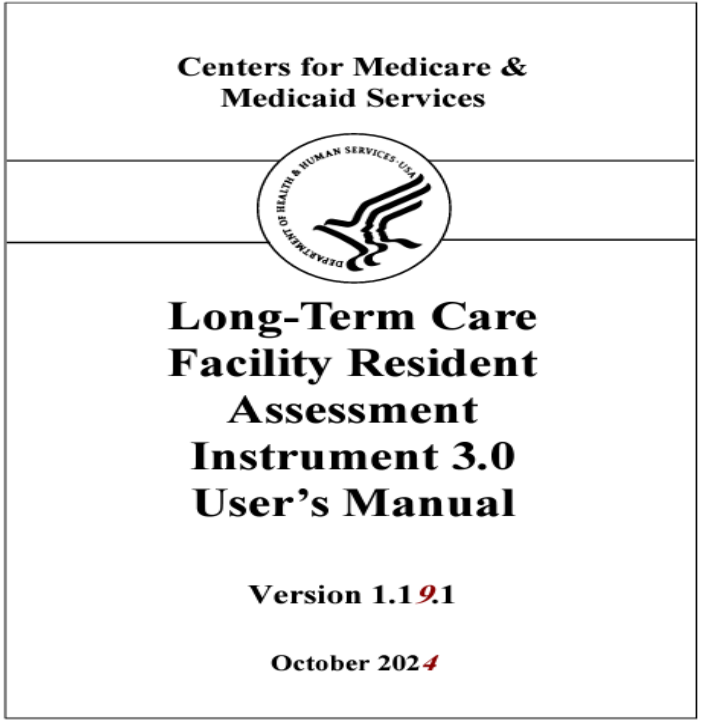
Helpful Links

- **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

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* brush*ing* and styl*ing* their hair *and* wash*ing* and dry*ing* their face *because of* elbow pain *after initiating the tasks, so a staff member completed these tasks*.

Updated

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

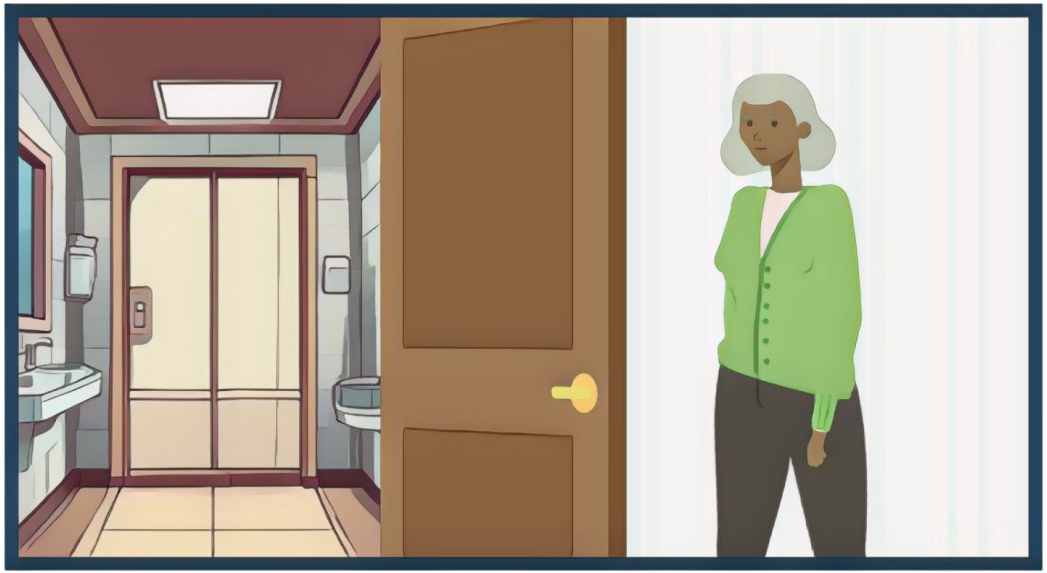
10 – Not attempted due to environmental limitations

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)

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:

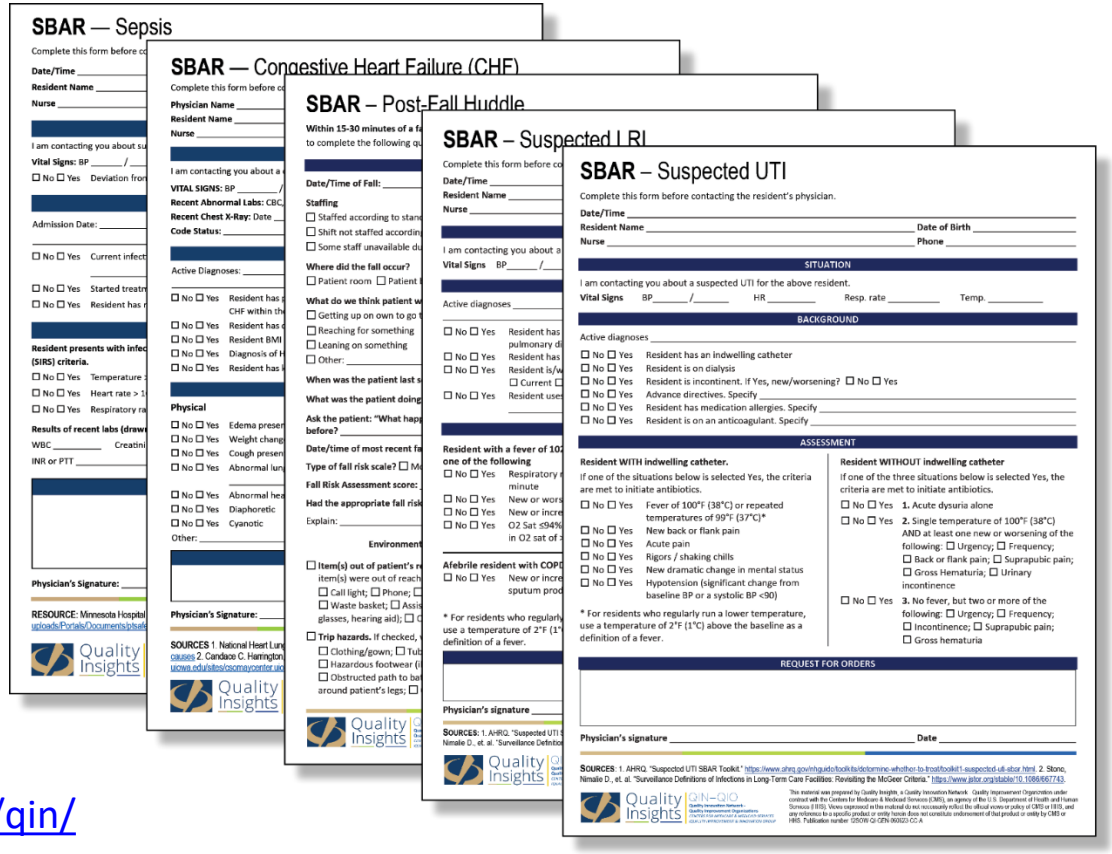
1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,

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

Section K: Swallowing/Nutritional Status

K0520: Nutritional Approaches
K0520B: Feeding Tubes

Removed Delivery of Medications from definition

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.

Section N: Medications

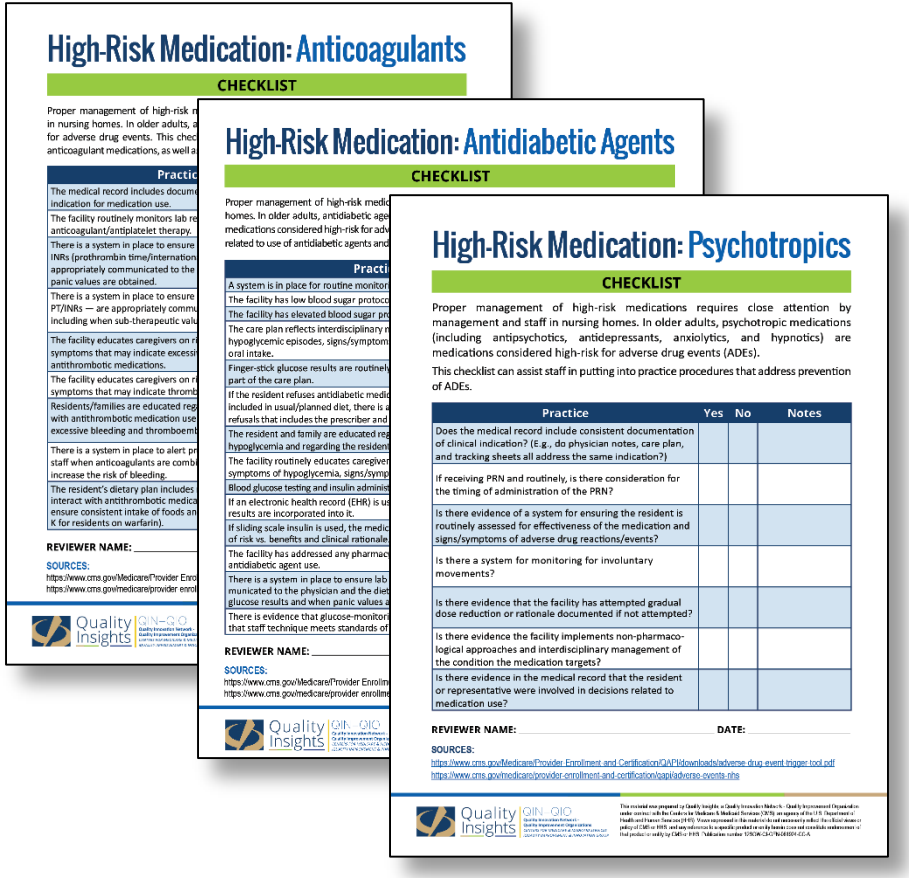
N0415: High-Risk Drug Classes: Use and Indication

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**

Additional Resources

High-Risk Medication Toolkits from Quality Insights

- Anticoagulants
- Antidiabetic Agents
- Psychotropic Medications



Section O: Special Treatments, Procedures, and Programs

O0110O1 – 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 O0110O1.

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:

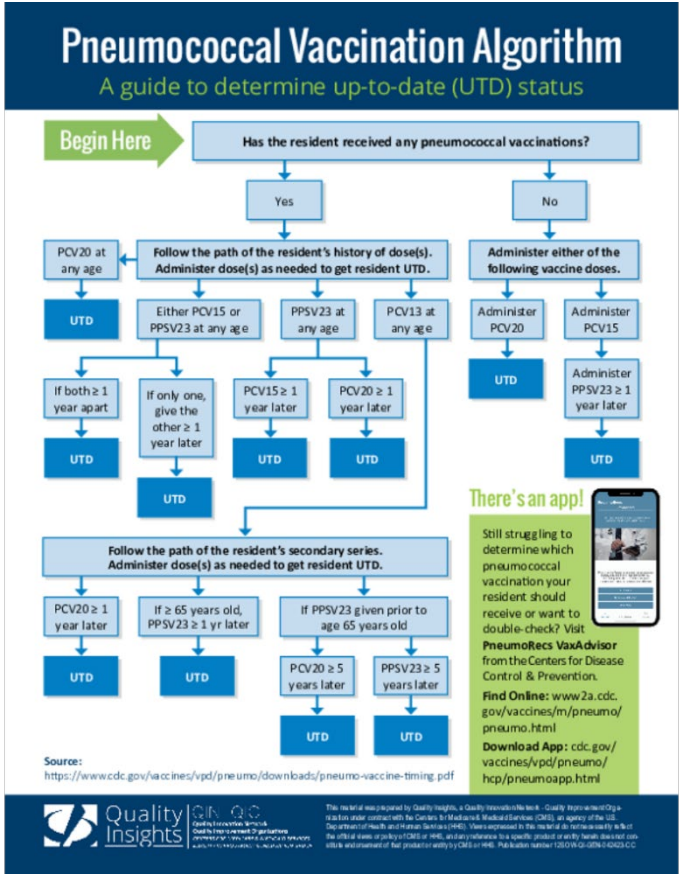
  https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccinetiming.pdf
- "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
- For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine 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 assesses. 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

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

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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