

SPECIAL REPORT

MDS 3.0 RAI MANUAL REVISIONS

Spring and Summer 2010

(A Section By Section Guide to the recent
CMS Revisions to the MDS 3.0 RAI Manual
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Chapter 1: The RAI

June 24:

1. On page 1-14, a revised Privacy Act Statement has been added.

Chapter 2: RAI Assessments

June 29:

1. Chapter 2 has undergone major some major revision and reorganization. This chapter should be read in its entirety again for the first time.
2. On page 2-6, new instructions have been added related to how to treat the MR in cases where discharge occurs and the resident returns within 30 days, not in 30 days and a long break has occurred of 15+ days.
3. On page 2-9 and 2-10, definitions have been added for Discharge Assessments, Interdisciplinary Team as well as Respite
4. On pages 2-10 through 2-12 a section has been added related to item set descriptions for NH and SB assessments.
5. On page 2-21 completing a SCOS with hospice election and now with revocation have been clarified. The ARD must be set on within 14 days of either the election date or the revocation date as appropriate.
6. On page 2-33, the rules governing the completion of a discharge assessment have been revised.
7. A discharge reentry flow chart has been added on pages 2-37 – 2-38. On pages 2-65 through 2-67, two new sections have been added related to the order assessments must be completed in and the item set identification based on coding in A310.

Chapter 3;

Section A: Identification Information:

June 28:

1. The definition for PPS (inset box) on page A-4 has been revised.
2. Clarifications have been made for the coding instructions for item A0310C related to the ARD for the start of therapy OMRA as it relates to the short stay assessment. Reference is made to chapter 6 for details.
3. On page A-5, the coding guidelines for item A0310E have been clarified to indicate that this item should be coded in relationship to the most recent entry of any kind, admission or reentry.
4. Also in relation to A310E, a Coding Tip has been added that indicates, *“A0310E = 0 for any tracking record (entry or death in facility).”*
5. Coding instructions for the SSN on page A-7 have been changed to indicate that item A0600 should be left blank if no SSN is available. Previous instructions indicated to dash fill.

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6. Also, for A0600, the following clarification has been made on page A-7, *“For PPS assessments (A0310B = 01, 02, 03, 04, 05, 06, and 07), either the SSN (A0600A) or Medicare number/RRB number (A0600B) must be present and both may not be blank.”*
7. The following clarification is also added for item 0600 B on page A-8, *“A0600B can only be a Medicare number or a Railroad Retirement Board number.”*
8. On page A-9, instructions have been added under coding instruction for item A0900, that indicate leaving portions of birth dates blank if they are unknown.
9. The following step #5 has been added under Steps for Assessment for item A1000 on page A-12.
 - *It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.*
10. The Health related Quality of Life section for item A1500, on page A-14 has been revised. **This is a major clarification and reorganization of this section and should be read thoroughly**
11. Coding guidelines for item A1500 on page A-10 have been amended to remove the instruction that indicated this item should be coded 0, if the PASRR was not completed as required.
12. On page A-18, coding guidelines for item A1700 have been added to clarify the meaning of admission and reentry.
13. On page A-19, clarification has also been made regarding Swing Bed responsibility in relationship to item A1700. CMS has also clarified the parameters for counting 30 days from discharge in relation to a return to the facility.
14. CMS has clarified at item A2000 on page A-21, that for discharge assessments, the discharge date (A2000), must be the same as the ARD date (A2300).
15. On page A-24, the third bullet under Coding Tips, regarding when a resident is admitted to the hospital prior to completing the admission assessment, has been removed.
16. Item Rationale for item A2400 has been added on page A-24.
17. On page A-25, the following clarification has been added regarding the end date of the most recent Medicare Stay since the most recent entry, item A2400;
 - *The end of Medicare date is coded as follows, whichever occurs first:*
 - *Date SNF benefit exhausts (i.e., the 100th day of the benefit); or*
 - *Date of last day covered as recorded on the Advance Beneficiary Notice of Noncoverage (ABN); or*
 - *Date the resident’s payer source changes from Medicare A to another payer (regardless if the resident was moved to another bed or not); or*
 - *Date the resident was discharged from the facility*
18. Several examples of Medicare stays have been added on page A-26.
19. There are a few other minor wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section B: Hearing Speech and Vision

June 3:

1. At the bottom of page B-1 under **code 1, yes**, the previous reference to section G 0110 as **Functional Status** has been revised to match the actual MDS 3.0 text, "**Activities of Daily Living (ADL) Assistance.**"
2. On page B-3, the following addition regarding hearing devices and appliances has been added to point #1 under Steps for Assessment. "*Hearing devices may not be as conventional as a hearing aid. Some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure whatever hearing appliance is used, it is operational.*"
3. On page B-10, the following points have been added as a more specific assessment technique, under B1000 Vision, Steps For assessment point 3, "*• When the resident is unable to read out loud (e.g. due to aphasia, illiteracy), you should test this by another means such as, but not limited to: Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper).*"
4. On page B-11, a Clarification has been added under B1200: Corrective lenses, Steps for Assessment point 1, to say, "*Visual aids do not include surgical lens implants.*"
5. There are a few other minor informal wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section C: Cognitive Patterns:

June 17:

1. On page C-1, the instructions for completing the BIMS verbally and in Writing under Steps for Assessment have been removed. These have been clarified on pages E-9 through E-10 in the revised Appendix E.
2. On page C-4, steps 10 regarding accents, and 11 regarding administering the BIMS and category cues, under Steps for Assessment have been removed. Step 11 is now bullet point 1 under Coding Tips on the same page and step 10 has been clarified in Appendix E as noted above.
3. The following bullet has been added under Coding tips on page C-4;
 - *Nonsensical responses should be coded as zero*
4. The following bullets have been added under Coding Tips for the BIMS on page C-5;
 - *When staff identify that the resident's primary method of communication is in written format, the BIMS can be administered in writing. **The administration of the BIMS in writing should be limited to this circumstance.***
 - *See Appendix E for details regarding how to administer the BIMS in writing.*
5. On page C-7, the portions of the instructions about what to do when communication is hindered because of an accent have been removed and clarified in Appendix C.
6. The dates in the examples listed on pages C-10 through C-12 have been changed to reflect a reference year of 2011.
7. The following clarification is added under the Coding Rationale for example #3 on page C-28;

- *If any information source reports the symptom as present, C1300A cannot be coded as 0, Behavior not present.*

There are a few other minor wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section D: Mood

June 3:

1. On page D-2, for clarification purposes, CMS has reworded point #1 under D0100 Steps for Assessment, to say, *“Determine if the resident is rarely/never understood. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).”*
2. On page D-2, CMS has removed specific reference to item B0700: Makes Self Understood, from both coding instructions for D0100 answers “yes” and “no”.
3. As was expected, on page D-4, CMS has added the word “Preferably” to Item D0200 Resident Mood Interview Steps for Assessment #1. It now reads, *“Conduct the interview preferably the day before or day of the ARD.”*
4. On page D-15, the severe depression severity score for the PHQ-9-OV has been corrected and now indicates, *“20 – 30.”*
5. There are a few other minor informal wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section E: Behavior

June 3:

1. On page E-1, a clarifying statement has been added mid paragraph under Intent, *“The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis.”*
2. On Pages E-3 and E-4, item E0100 coding examples #1 has been removed and replaced by a new example #1;
 - *A resident carries a doll which she believes is her baby and the resident appears upset. When asked about this, she reports she is distressed from hearing her baby crying and thinks she’s hungry and wants to get her a bottle.*
 - **Coding:** *E0100A would be checked and E0100B would be checked.*
 - **Rationale:** *The resident believes the doll is a baby which is a delusion and she hears the doll crying which is an auditory hallucination.*
3. On Page E-8 under Coding Tips and Special Populations for E0500, bullet point #1 describing the term “significant” as it applies to coding items E0500 A-C, has been removed.
4. On page E-9, while the answers remain the same, the coding example #2 narrative, for item E0500, has been changed to the following;
 - *During the last 7 days, a resident with vascular dementia and severe hypertension, hits staff during incontinent care making it very difficult to change*

her. Six out of the last seven days the resident refuses all her medication including her antihypertensive. The resident would close her mouth and shaking her head and will not take it even if re-approached multiple times.

5. On Page E-11 under Coding Tips and Special Populations for E0600, bullet point #1 describing the term “significant” as it applies to coding items E0600 A-C, has been removed.
6. On page E-11, in the narrative for Coding Example #2 for E0600, the following has been removed from the previous version of the Manual; “*Staff are diverted from other activities to manage the resident’s distress.*”
7. On page E-13, an excellent point of clarification has been added regarding the Item rationale for item E0800: Rejection of Care – Presence and frequency. Bullet point three, under Health related Quality of Life, has been added and states, “*It is really a matter of resident choice. When rejection/decline of care is first identified, the team then investigates and determines the rejection/decline of care is really a matter of resident’s choice. Education is provided and the resident’s choices become part of the plan of care. On future assessments, this behavior would not be coded in this item.*” In essence, What CMS appears to be indicating is that the behavior, rejection of care, would be coded the first time it was identified. Then once the determination is made that the behavior is consistent with the resident’s preferences and goals, it would be addressed in the care plan and would not be coded as a behavior on future assessments.

8. On Page E-14, the following clarifying definitions box has been added;

DEFINITIONS

REJECTION OF CARE

Behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care.

INTERFERENCE WITH CARE

Hindering the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.

9. On page E-15 the incorrect skip directions to skip to item E1000: Wandering Impact, under Coding Instructions for item 0800, **code 0, behavior not exhibited**, have been removed.
10. On page E-19, the following bullet point #1 has been removed from under the Item Rationale, Health Related Quality of Life, for item E-1000: Wandering – Impact; *“Distinguish between wandering that is an adaptive or valued behavior versus wandering that represents a behavioral problem with a negative impact on the resident or others.”*
11. On page E-19 the following has been added to the end of point #2 under Steps for Assessment for item E1000: Wandering – Impact; *“based on clinical judgment for the individual resident.”*
12. On page E-20 the Coding Tips and Special Populations for E1000: Wandering – Impact , inc. bullet point #1 describing the term “significant” as it applies to coding items E1000 A, has been removed.
13. There are a few other minor informal wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section E: Behavior

June 9: (second revision)

1. There have been only minor numbering revisions to the examples on page E-3. The number 2 has been added to the second example and the examples that follow have been renumbered accordingly. This is in addition to and has been revised since the June 3 revision to Section E. Just replace that page. The rest of the section has not been changed.

Section F: Preferences for customary Routines and Activities

June 3:

1. On page F-1, the following has been added to the end of the paragraph under Intent; *“The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident’s preferences, and is not meant to be all-inclusive.”*
2. Also on page F-1, point one under Steps for assessment for item F0300 has been revised to read, *“Determine whether or not resident is rarely/never understood and if family/significant other is available. If resident is rarely/never understood and family is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.”*
3. On page F-14, the following was added at the end of the coding instructions for F0700, *“or a “-“.*
4. Also on page F-14, the single bullet point under Coding Tips and Special Populations has been revised to read, *“If the total number of unanswered questions in F0400 through F0500 is equal to 3 or more, the interview is considered incomplete.”*

5. There are a few other minor informal wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section G: Functional Status

June 15:

1. The rule of three guidelines on page G-4 now include the following clarifications (n the underlined portions have been added to the June update to this section);
 - *Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance—this is total dependence).*
 - *When there are three or more episodes of a combination of full staff performance and weight-bearing assistance—code extensive assistance (3).*
 - *When there are three or more episodes of a combination of full staff performance, weight-bearing assistance, and non-weight-bearing assistance—code limited assistance (2).*
2. The ADL self performance algorithm on page G-6 has been revised to include the underlined language in bullets 2 and 3 above.
3. On page G-7, the following clarification, as is present on the MDS 3.0 form instructions, has been added under Coding Tips, *“Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I.”*
4. A Balance during Walking Algorithm has been added to page G-21.
5. On page G-29, the following Intent has been added under GO400 – Functional Limitation in ROM;
 - *The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident’s activities of daily living or places him or her at risk of injury. When completing this item, staff should refer back to item G0110 and view the limitation in ROM taking into account activities that the resident is able to perform.*
6. On page G-30, the Steps for Assessment for item G0400 have been significantly revised and added to. **This is a major clarification and reorganization of this section and should be read thoroughly.**
7. Example #1 on page G-31 has been revised.
8. There are several other minor wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section H: Bladder and Bowel

May 28:

1. On page H-1, Under Intent, CMS has clarified the term, Individual Treatment, by adding the following in parentheses, *“(medications, non-medicinal treatments and/or devices)”*.
2. On page H-2, under steps for assessment, the numbers delineating steps 1 and 2 have been removed.

3. Also on page H-2, the time frame, *“every 3-6 hours”*, has been removed from the definition of intermittent Catheterization, in the right inset.
4. Finally on page H-2, the following has been added as the last bullet point under Coding Tips and Special Populations; *“Do not include one-time catheterization for urine specimen during look back period as intermittent catheterization”*.
5. On page H-5, under Coding instructions for H0200A, in the coding guidelines for Code 1, yes, **“prior assessment”** has been bolded.
6. On page H-6, Under Example, for example 1, the coding and rationale have been revised to reflect a more accurate coding of the scenario presented in example 1. The answers have been changed from H0200A - 1, yes, H0200B – 0, no and H0200C – 0, No, to **“Coding: H0200A would be coded as 0, no H0200B and H0200C would be skipped.”** The rationale was also revised and now reads, **“Rationale: Based on this resident’s voiding assessment/diary, there was no pattern to her incontinence. Therefore, H0200A would be coded as 0, no. Due to total incontinence a toileting program is not appropriate for this resident. Since H0200A is coded 0, no skip to H0300, Urinary Continence.”**
7. On page H-2, under Example , for example 2, the correct coding for H0200B has been revised from 1, decreased wetness, to, **“H0200B would be coded as 9, unable to determine or trial in progress.”** The rationale for this coding has also been revised and now reads, **“Rationale: Based on this resident’s voiding assessment/diary, it was determined that this resident could benefit from a toileting program. Therefore H0200A is coded as 1, yes. Based on the assessment it was determined that incontinence episodes could be reduced, therefore H0200B is coded as 9, unable to determine or trial in progress. An individualized plan has been developed, implemented, and communicated to the resident and staff, therefore H0200C is coded as 1, current toileting program or trial.”**
8. The final revision for section H is on page H-13. Here CMS has added a **Coding Tips and Special Population** Heading. Under this heading, CMS has added one bullet point, **“Fecal impaction is constipation.”** With this coding clarification, it is clear that CMS intends for fecal impaction to be coded as constipation in H0600.

Section I: Active Diagnoses

May 25:

1. The lookback for physician documentation related to active diagnosis has been extended from 30 days to 60 days.
2. Clarification has been made on how ICD-9 codes are to be entered in section I1800.
 - *Page i-4 indicates, “Computer specifications are written such that the ICD code should be automatically justified. The important element is to insure that the ICD code’s decimal point is in its own box and should be right justified (aligned with the right margin so that any unused boxes and on the left.)”*.
3. Clarification has been made regarding the fact that the dx UTI has specific guidelines and is a 30-day lookback period not a 7 day lookback for active status. Note also that

clarification has been made regarding coding a UTI if the organism is determined to be colonized MRSA.

- *Page I-8 and I-9 indicate,*
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 all the following are met**
 1. *Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days,*
 2. *Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g. pyuria),*
 3. *“Significant laboratory findings” (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and*
 4. *Current medication or treatment for a UTI in the last 30 days.*
- *Regarding Colonized MRSA, the manual indicates, “The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism.* The coding guidelines for colonized MRSA, it seems, is the same as any other organism, and is contingent on the 4 criteria for coding UTI listed above. If these criteria are met, you would indeed code a UTI even when colonized MRSA is the organism in question.

One final clarification that needs to be made is this issue of what documentation source qualifies as physician documentation for the now 60-day look back, to **identify diagnosis**. On page I-3, the manual indicates, *“Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.* After further consideration, I believe that this is not indicating that the diagnosis/problem list can be used a source for physician documented diagnosis in the last 60 days. What this is referring to is that if the facility does use a diagnosis/problem list, the only diagnoses that can be listed on that document are physician confirmed diagnoses. Therefore, I believe that the discussion of the most efficient and productive way to get physician documentation to support our coding in section will be a challenge.

Section J: Health Conditions

June 10:

1. On page J-3, a reference to the controlled release form of Morphine Sulfate, MS Contin, has been removed from example 2.
2. At the bottom of page J-6 under Steps for assessment for J0300 – J0600, former steps 2 and 3 have been combined into one step 2.
3. On page J-8 – J-14 under the coding guidelines for items J0300, J0400, J0500 A and B and J0600, clarifications have been added as to which items to proceed to if certain items are coded a “1” or a “9”.
4. On page J-15, the following has been added under the Item Rationale for item J0700; *“Item J0700 closes the pain interview and determines if the resident interview was complete or incomplete and based on this determination, whether a staff assessment needs to be completed.”*
5. On page J-15, the following step #2 has been added under Steps For Assessment for item J0700, *“The **Staff Assessment for Pain** should only be completed if the **Pain Assessment Interview (J0200-J0600)** was not completed.”*
6. On page J-15, the following has been added at the end of the coding instructions for item J0700, *“**This item is to be coded at the completion of items J0400-J0600.**”*
7. On page J-17, a clarification has been made to each of the coding instructions for items J0800 A – D. Each instruction now begins with the phrase, *“**Including but not limited to...**”*
8. On page J-25, the fever and Vomiting Definition inset box has been removed and the definitions for fever and vomiting, formerly contained in the box, have been added to the text under Coding Tips. The directions for determining a fever prior to establishing a baseline temperature are delineated now with the following bolded heading, *“**Fever assessment prior to establishing a baseline temperature:**”*
9. On page J-26, the following clarifications have been added to the definition of Dehydration. First, the word *“potential”* has been added to the sentence, indicating which items to check. Second, in point #1 describing Dehydration, in the sentence *“Resident usually takes in less..”* the word *“usually”* has been removed and this now reads, *“Resident takes in less...”*
10. Also on page J-26, the following items have been added to the description of what not to code for J1550H, Internal Bleeding, *“...menses, or a urinalysis that shows a small amount of red blood cells...”*
11. There are several other minor wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section K: Swallowing/Nutritional Status

May 28:

1. On page K-3, CMS removed the additional instructions originally listed for measuring the height of a resident who is unable to stand and must lie flat in bed due to, for example, an amputation of a lower extremity, or unable to lie flat in bed due to contractures. It appears that CMS is relying on the fact that providers know what standards of practice are and that providers will follow these when it comes to residents for whom it is difficult to obtain a height. These were previously points 4 – 6 under Steps for assessment for K0200A, Height.
2. On page K-4, CMS inserted a clarification, in point 5 under Steps for Assessment for K0200B, to the standard nursing home practice of weighing residents consistently over time by adding the phrase, *“including time of day or scale”*.
3. On pages K-7 and K-8, this is not a revision, however, please note the instructions for calculating weight loss due to amputation. Also, it appears that the actual calculations for % loss in the weight loss examples due to amputation are not correct even in the revised manual. Please just stick with the calculation instructions for weight loss in the right inset on pages K-4 and K-5.
4. On page K-9, CMS has repositioned the clarification related to the lookback period for nutrition and hydration that was located at the bottom of page K-9 previously, to a highlighted notation directly under the heading, “Coding Tips”. The text of this clarification has not changed other than some bolding for emphasis, however it is worth noting again, *“K0500 includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, **provided they were administered for nutrition or hydration**”*.
5. Also on page K-9, CMS has clarified the coding parameters for items in K0500A by adding the following in bullet point 1 under Coding Tips, *“**Parenteral/IV feeding—The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident’s medical record according to State and/or internal facility policy:**”*
6. Also on page K-9, the following revisions have been made to the items that are listed as not to be coded in K0500A.
 - The heading for these items has been revised to read, *“**The following items are NOT to be coded in K0500A:**”*
 - The following has been added to this list.
 - *“IV fluids administered solely for the purpose of “prevention” of dehydration. Active diagnosis of dehydration must be present in order to code this fluid in K0500A.”*
 - The following have been removed from the previous list of these guidelines:
 - *IV fluids used to reconstitute and/or dilute medications for IV administration unless there is a documented need for additional fluid intake for nutrition and/or hydration. This supporting documentation*

should be noted in the resident's record, according to State or internal nursing home policy.

- *Additives, such as electrolytes and insulin, that are added to TPN or IV fluids—**Code these in O0100H, IV Medication.***
7. On page K-10, the following bullet has been added:
 - *“Guidelines on basic fluid and electrolyte replacement can be found online at <http://www.merck.com/mmpe/sec19/ch276/ch276b.html>.”*
 8. Also the coding clarification for Enteral Feeding Formulas has been moved to page K-10 and the following clarifications have been made to the second sub point under this heading.
 - *“should only be coded as **K0400D, Therapeutic Diet** when the enteral formula is to manage problematic health conditions, e.g. enteral formulas specific to diabetics.”*
 9. Also on page K-10, the following has been removed from the coding rationale in example 1; *“needed to reconstitute the antibiotic”*, since that directive was removed as noted above.
 10. Also on page K-10, the following statement previously found in the coding rationale in example 2, *“the fluid needed to reconstitute the antibiotic,”*, has been replaced by, *“the additional fluid”*.
 11. Finally, on page K-10, the Item Rationale for K0700 has been moved to page K-11.
 12. On page K-11, the coding rationale under K0700A example 1 has been moved to K-12.
 13. The coding rationale for K0700B example 1 previously on page k-12 has been moved to page K-13
 14. On page K-13, a second coding example for item K0700B has been added to illustrate less than 500 cc of fluid/day.

Section K: Swallowing/Nutritional Status

July 7 (Second Revision)

1. This update is related to a clarification of the example for calculating weight loss for item K0300; **the content of this section has not changed.**

Section L: Oral/Dental Status

May 25:

1. On page L-2, point 6 under Steps for Assessment, the following **bolded** language has been added to the issue regarding uncooperative residents. *“Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents **and any resident who exhibits dental or oral issues.**”*

Section M: Skin Conditions

July 12:

1. A note about the importance of the knowing etiology of a wound for proper wound treatment has been added to the end of the first paragraph on page M-1.
2. Clarification related to the terms “Healed” and “Unhealed”, as well as the tenability of closed pressure ulcers, has been added to the bottom of page M-1.
3. A clarification regarding the NPUAP guidelines vs. the Adapted NPUAP guidelines found in the RAI Manual has been added to bullet point 3 under “Planning For Care” on page M-4.
4. The following Steps For Assessment have been added to all stages of pressure ulcers. *“1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
2. For the purposes of coding, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **NOT** the **primary** cause, do **NOT** code here.”*
5. The following clarification regarding stage 1 pressure ulcers has been added as point 3 on page M-7. *“Reliance on only one descriptor is inadequate to determine the staging of the pressure ulcer between Stage 1 and suspected deep tissue ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature (warmth or coolness); tissue consistency (firm or boggy).”*
6. The following clarification related to stage 2 pressure ulcers has been added as point 3 on page M-9, *“Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury rather than a Stage 2 Pressure Ulcer.”*
7. The definition for stage 3 pressure ulcer on page M-10 has been revised.
8. The definition for stage 4 pressure ulcer on page M-13 has been revised.
9. The definitions of Slough Tissue and Escar Tissue, on page M-15 and M22, have been revised.
10. Clarifications have been made to the examples for coding unstageable pressure ulcers on pages M-16 and M-17.
11. Several helpful clarifications have been added to pages M-18 and M-19 related to Unstageable Pressure Ulcers related to Deep Tissue injury.
12. Clarifications have been made to example 3 on page M-25, related to coding worsening pressure ulcers.
13. The definition for Hemosiderin has been added to page M-28.
14. An example related to coding Venous and Arterial ulcers has been added to page M-29.
15. Clarifications have been added to the instructions for coding M1200H and M1200I on pages M-34 and M-35.
16. Example 2 for coding Skin treatments has been added to page M-35.
17. Pages M-37 through M-52 now contain scenarios for pressure ulcer coding along with examples of correct coding related to those scenarios.

18. There are several other minor wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section N: Medications

May 25:

1. On page N-1 number 2 under Steps for Assessment, CMS has clarified that recording the number of days the resident received injections, while a resident of the nursing home, can include injections given in the E.R. as long as the resident was not admitted to the hospital.
2. On page N-3. CMS has clarified when subcutaneous pumps can be counted as insulin injections. *“For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.”*
3. The brand names of medications have been removed leaving only the generic names of medication in the text of the Manual. For example; on page N-5, Aggrenox has been removed leaving only Dipyridamole, Similarly on page N-6, Serax, Prolixin, and Haldol have been removed leaving Oxazepam, Fluphenazine and Haloperidol Deconate.
4. On page N-8 note the following revisions;
 - First a paragraph has been added to clarify the coding of herbal preparations in section N. Essentially, CMS indicates that herbal preparations are “dietary supplements”, and are not to be counted in section N as Medications. However, CMS also clarifies that that for clinical purposes, these preparations should be documented elsewhere in the medical record to monitor for side effects and possible interactions with other medications. CMS also offers a FDA website for more information gathering.
 - Regarding the coding of herbal preparations on the MDS one must consider that MDS 3.0 section K no longer contains the item for Dietary Supplements between meals. The only place that nutritional supplements are noted in section K in MDS 3.0 is in the instructions for coding item K0700B, “Average fluid intake by IV or tube feeding”. The only other place nutritional supplements are noted is in the examples on page M-33, and relate to coding for the items in M1200, specifically in M122B, “Nutrition and Hydration Interventions”. Therefore, to code herbal preparations on MDS 3.0, they would have to meet the narrow definitions in either section K or section M. They would never be coded in section N.
5. Also on page N-8, CMS changed one medication in the coding example from Haloperidol to Risperidone. In this example, they have also rearranged the location of clarification of the medication classes, used in the example, to follow the medication names rather than following the end of the example under the heading Rationale as they were before. CMS has also clarified that if all three classes of medication, Antipsychotic, Antianxiety, and Hypnotic medication are used, that there must be a clinical indication for their use as this particular combination could be considered chemical restraint. CMS has added the statement that, “Adequate documentation is essential in justifying their use.”

6. Finally, CMS has added two resource websites for additional medication information. The Orange book and The National Drug Code Directory.

Section O: Special Procedures, treatments and Programs

June 10:

1. Any reference to section O has been revised to indicate Special Treatments, Procedures and Programs, which was Special treatments, Programs and Procedures in the previous version of the Manual.
2. The reference to the brand name Megace has been removed from page O-2.
3. A clarification regarding coding IV medications has been added to page O-3 indicating, *“Do not include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here.”*
4. A clarification regarding determining the annual flu season has been added to page O-6. *“The Influenza season varies annually. Information about current Influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website: <http://www.cdc.gov/flu>.”*
5. Clarification has been added on page O-15 related to the specifics of the therapy start and end dates.
 - **Therapy Start Date**—... *This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not.*
 - **Therapy End Date**—... *This is the last date the resident received skilled therapy treatment.*
6. Pages O-17 – O-21 have been revised to clarify the proper coding of therapy minutes, days and start and end dates. **This is a major clarification and reorganization of this section and should be read thoroughly**
7. Each Restorative program description found, on pages O-29 through O-30, now contains the following additional clarification, *“These exercises must be individualized to the resident’s needs, planned, monitored, evaluated and documented in the resident’s medical record.”*
8. On page O-35, the following clarification has been added related to item)700 – Physician orders, *“Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.”*
9. There are several other minor wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section P: Restraints

May 25:

1. On page P-1, CMS has included a more specific reference and web link to a CMS Memorandum to state survey agencies that more specifically defines physical restraints as they apply to the LTC setting, from June of 2007.

2. Also, on page P-1 Under the heading, Are Restraints Prohibited by CMS?, CMS has clarified the “**except** under certain circumstances” clause, by broadening the term to say, *“CMS guidelines do not prohibit use of restraints in nursing homes, **except** when they are imposed for discipline or convenience and are not required to treat the resident’s medical symptoms.”*
3. Under steps for assessment, on Page P-3, CMS combined some material and created a separate point 5 which indicates, *“A device should be classified as a restraint only when it meets the criteria of the restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every device (whether or not it is listed specifically on the MDS) and its effect on the resident.”*
4. On page P-6, under “Chair Prevent Rising”, CMS has shifted the order of two of the sub points, with no change to the clarification text.

Section Q: Participation in Assessment and Goal Setting

June 15:

1. On page Q-8, the following additional clarifications have been added to bullets 2 and 3 under Health related quality of Life for item Q0400;
 - *For residents that have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. There are improved community resources and support*
 - *... so a thorough examination of the options with the resident and local community experts is imperative.*
2. The following bullet has been added under Planning for Care on page Q-8
 - *Important progress has been made so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the U. S. Supreme Court Olmstead ruling, which states that residents needing long-term care services have*
3. On page Q-9, the several steps have been added under planning for Care for item Q0400. **This is a major clarification and reorganization of this section and should be read thoroughly.**
4. The following Coding Tips have been added for Item Q0400 on page Q-10
 - *This item is individualized and resident-driven, and the interdisciplinary team must interview residents and/or their family members, whenever possible, and determine their preferences and agreement.*
5. There are a few other minor wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section V: Care Area Assessment Summary

June 17:

1. On page V-1, the paragraphs here have been moved around for clarity and the final paragraph, from the previous version of the manual regarding CAAs that compare current assessments with prior assessments, has been removed.
6. On page V-2, the rationale for items in V0100 has been completely rewritten. **This is a major clarification and reorganization of this section and should be read thoroughly.**
2. On page V-2 through V-3, the following clarification has been made to each of the coding instructions for items V0100A – V0100F, regarding the previous PPS assessment that the current assessment is being compared to;
 - *...or scheduled PPS assessment, if one is available (see "Item Rationale", above, for details)*
3. There are a few other minor wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section X: Correction Request

May 28:

1. All references to the MDS National repository have been replaced by the ***"QIES ASAP database"***. **ASAP** stands for Assessment Submission and Processing.
2. Instructions for completing X0150, type of provider, which were omitted from the original RAI manual version, have been added back in this revised version at the top of page X-4.
3. Coding instructions for items X0200B, middle initial, and X0200D suffix, have been omitted from the revised Manual on page X-4.
4. Instructions for completing X0600D, is this a Swing Bed clinical change assessment, which were omitted from the original RAI manual version, have been added back in this revised version on page X-7.
5. Instructions for completing X0600F, Entry/Discharge Reporting, which were omitted from the original RAI manual version, have been added back in this revised version at the top of page X-8.
6. Clarification to coding instructions for X0700, date on existing record to be modified or inactivated, has been added on page X-8. ***"Enter only one date in X0700"***.
7. Clarification to the coding instructions for X0700B has been added to bullet point one under that heading on page X-9, regarding how to code the ARD (A2300) and the discharge date (A2000) if the record being modified was an OMRA Discharge combination.
8. A clarification has been added to the coding guidelines for item X0800 Correction Attestation Section on page X-9. ***"This item may be populated automatically by the nursing home's date entry software, however, if it is not, the nursing home should enter this information."***

9. There are several other minor informal wording and formatting revisions for clarification purposes. However, no other substantive textual or instructional changes have been noted.

Section Z: Assessment Administration

June 9:

1. On Page Z-1, bullet #2 under coding Instructions for Z0100A, a clarification has been made to indicate that the HIPPS code is a five-position code as opposed to a three-position code as was previously noted.
2. Also on page Z-1, the following bullet #6 has been added under coding Instructions for Z0100A, *“Left-justify the 5-character HIPPS code. The extra two spaces are supplied for future use, if necessary.”*
3. On page Z-2, a third bullet has been added under coding Instructions for Z0100B, *“With MDS 3.0 implementation on October 1, 2010, the initial Medicare RUG-IV Version Code is “1.0066”.”*
4. On page Z-2, the following clarification has been made to the Item Rationale for item Z0150, *“Used to capture the Resource Utilization Group non-therapy (RUG) followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment. The non-therapy RUG is the code obtained when all rehabilitation therapy is ignored and will be limited to the Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavior and Cognitive Performance, and the Physical Function codes.”*
5. On Page Z-3, bullet #2 under coding Instructions for Z0150A, a clarification has been made to indicate that the HIPPS code is a five-position code as opposed to a three-position code as was previously noted.
6. Also on page Z-3, the following bullet #4 has been added at under coding Instructions for Z0150A, *“Left-justify the 5-character HIPPS code. The extra two spaces are supplied for future use, if necessary.”*
7. On page Z-2, a third bullet has been added under coding Instructions for Z0150B, *“With MDS 3.0 implementation on October 1, 2010, the initial Medicare RUG-IV Version Code is “1.0066”.”*
8. On pages Z-6 and Z-7, in bullet #1 under Item Rationale and bullets #1 and #2 under Coding Instructions for item Z0400, CMS has clarified that each person completing even a, *“... portion of a section of the MDS...”*, is required to sign the Attestation Statement.
9. On page Z-7, the following two bullets have been added under Coding Tips and Special Populations for item Z0400;
 - *“Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a sub-set of item within a section should identify which item(s) he/she completed within that section.”*
 - *“Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a “copy” document and not the original.”*

10. On page Z-8, the last two bullets, previously included under Coding instructions for item Z0500, have been removed.
11. Also on page Z-8, the following bullet has been added under Coding Tips for item Z0500;
 - *“Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a “copy” document and not the original.”*
12. There are a few other minor informal wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Chapter 4: CCAA/Care planning

June 17: The revision to Chapter 4 has been temporarily removed from the CMS website. On July 26th the following announcement was posted by CMS regarding Chapter 4; *“Chapter 4 of the MDS 3.0 RAI Manual has been removed secondary to some errors that were identified with the Care Area Triggers. We hope to have the corrected version published by the end of this week”.*

Chapter 5: Submission and Correction

June 28:

1. At the top of page 5-8, a revision to the first two paragraphs has been made related to correcting a MDS assessment that has been accepted into the QIES ASAP system.
2. The Modification Request guidelines on page 5-10 have been revised.
3. The inactivation Request directives at the bottom of page 5-11 have been clarified.
4. A Correction Policy Flowchart has been added to chapter 5 on page 5-14.
5. There are a few other minor informal wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Chapter 6: SNF PPS

July 1:

1. A clarification has been added to the bottom of page 6-6 regarding the RUG IV group codes that impact the HIPPS code.
2. A clarification regarding how stand-alone unscheduled assessments used for PPS will affect payment periods, has been added to the bottom of page 6-8.
3. Table 3 on pages 6-9 through 6-11 has had several revisions to the text regarding how each assessment/assessment combination, affects payment periods.
4. On page 6-14, CMS has added a Medicare Short Stay Assessment algorithm.
5. A Rehab minute calculation example has been added to page 6-21.
6. On page 6-23, instructions to discard all numbers after the decimal point and record the result, in relation to the average short stay rehab minutes, has replaced the previous instruction. Previously the instructions indicated that the average should be rounded to the nearest whole minute.

7. There are a few other minor informal wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Appendix A: Glossary:

July 19:

1. Appendix A has been completely revised. Many of the Glossary items have been removed and simply retained in the text of the chapter to which they apply. Some of the definitions that have been retained in this appendix have been rewritten for clarification. For accurate MDS 3.0 completion, the version of Appendix A, published in November 2009, should be completely discarded and reference should only be made to the July 2010 version.

Appendix B: Contacts

June 23:

1. Appendix B has simply been updated to reflect the changes to the contacts listed on these pages.

Appendix C: CAA Resources

June 25:

1. This appendix has been revised to include the Care Area Specific Resources that have been provided as a courtesy by CMS for the completion of the CAA process.

Appendix D: Interviewing

June 23:

1. There are a few minor informal wording and formatting revisions for spacing and clarification purposes. However, no other substantive textual or instructional changes have been noted.

Appendix E: CPS and BIMS

June 24:

1. Scoring rules for the Mood Interview and Staff Assessment of Mood Interview have been added on pages E-4 through E-9.
2. On pages E-9 through E-16, Instructions for administering the BIMS in writing as well as the cue cards necessary for this process, have been added.

Appendix F: Draft Matrix

July 19:

1. Appendix F has not been revised.

Appendix G: References

June 24:

1. Appendix G has been revised to include additional references provided by CMS.

Appendix H: Item Sets

July 19:

1. Appendix H has not been revised since changes were made to the MDS 3.0 version 1.00.2 in April 2010.