"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

MDS 3.0 1.19.1 and Beyond.

Updates to the new data set

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Vice President of PAC Regulatory Affairs and Education

ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
  - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
  - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after 30 days

Learning Objectives

MDS 3.0 1.19.1 and Beyond

- Understand upcoming changes to the MDS
- Grasp the key ideas behind social determinants of health
- Identify the FY 2025 changes in MDS 3.0v1.19.1
- Recognize the revisions the CMS will implement in FY 2026

Agenda

MDS 3.0 1.19.1 and Beyond

- Review the item set changes
- Walk through the RAI Manual revisions
- Discuss upcoming FY 2026 changes
- Review SDOH

Resources

- MDS 3.0 Manuals and Change Tables
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Data Set Changes: Section A

Current A310 G
MDS 3.0 v1.18.11
(NPE, IPA)

Item revised: Completion instructions deleted.

RevisedA310 G
MDS 3.0 v1.19.1
(NPE, IPA)

A0310. Type of Assessment - Continued

Enter Code ☐

G. Type of discharge - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

A0310. Type of Assessment - Continued

Enter Code ☐

G. Type of discharge
1. **Planned**
2. **Unplanned**

Data Set Changes: Section A

Current A 1250
MDS 3.0 v1.18.11
(ND)

Item revised: Language deleted from completion instructions: A0310B = 01 or

Revised A 1250
MDS 3.0 v1.19.1
(ND)

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓	Check all that apply
☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310G = 1 and A0310H = 1

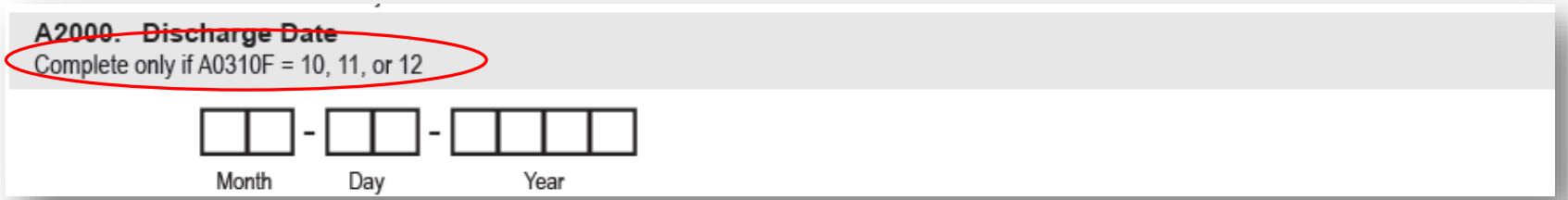
↓	Check all that apply
☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

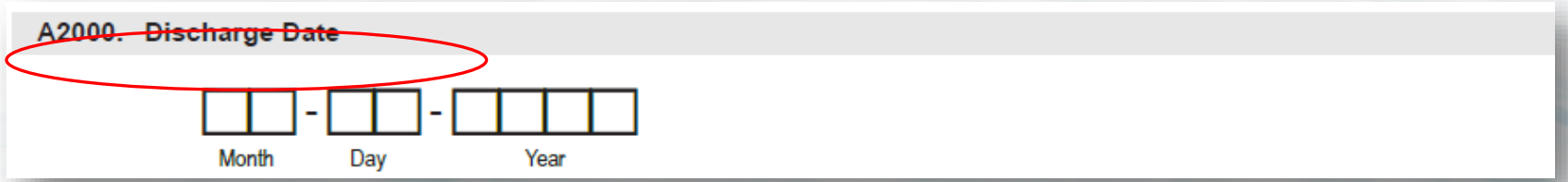
Data Set Changes: Section A

Current A 2000
MDS 3.0 v1.18.11
(NPE)

Item revised: Completion instructions deleted.

Revised A 2000
MDS 3.0 v1.19.1
(NPE)





Data Set Changes: Section A

Current A 2121
MDS 3.0 v1.18.11
(NPE)

Item removed.

Revised A 2121
MDS 3.0 v1.19.1
(NPE)

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Complete only if A0310H = 1

Enter Code ☐

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2300, Assessment Reference Date
1. **Yes** - Current reconciled medication list provided to the subsequent provider

Removed

Data Set Changes: Section A

Current A 2122
MDS 3.0 v1.18.11
(NPE)

Item removed.

Revised A 2122
MDS 3.0 v1.19.1
(NPE)

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Complete only if A2121 = 1

↓	Check all that apply
	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

Removed

Data Set Changes: Section B

Current B1300
MDS 3.0 v1.18.11
(NP)

Item revised: Completion instructions deleted.

Revised B1300
MDS 3.0 v1.19.1
(NP)

B1300. ~~Health Literacy~~

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

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B1300. Health Literacy

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

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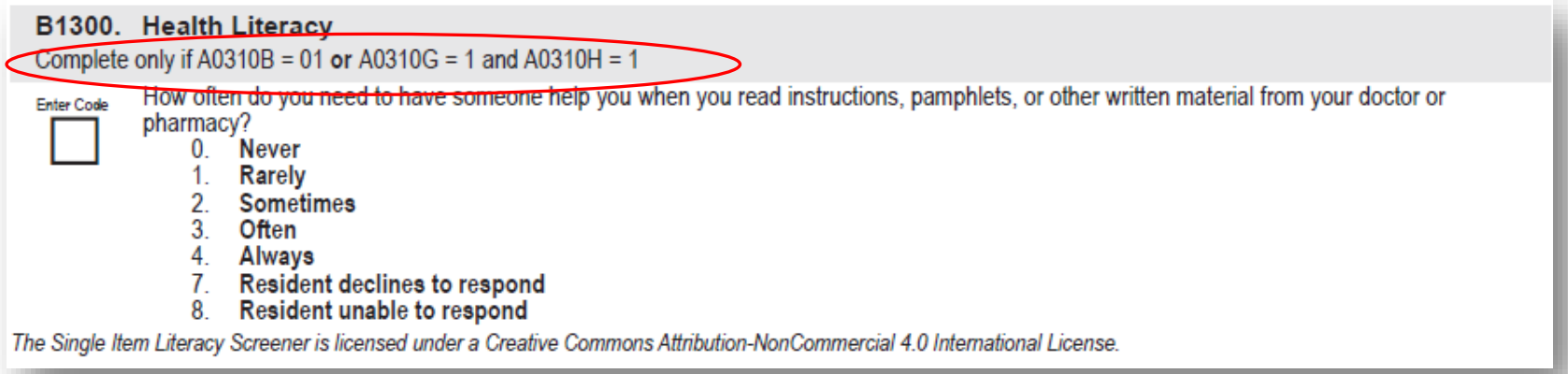
Data Set Changes: Section B

Current B1300 MDS 3.0 v1.18.11
(ND)

Item revised: Language deleted from completion instructions:
A0310B = 01 or



B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. Never
1. Rarely
2. Sometimes
3. Often
4. Always
7. Resident declines to respond
8. Resident unable to respond

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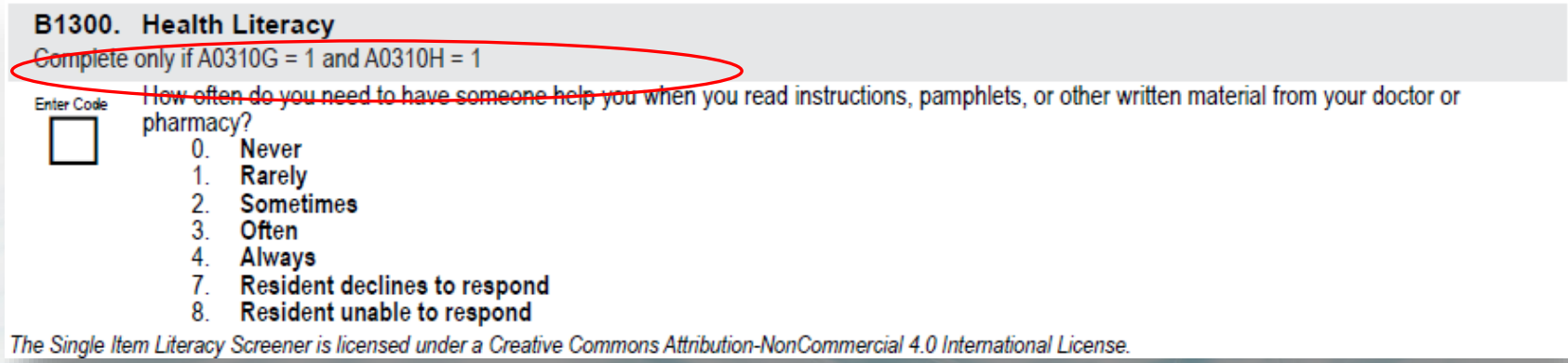
Revised B1300 MDS 3.0 v1.19.1
(ND)



B1300. Health Literacy

Complete only if A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. Never
1. Rarely
2. Sometimes
3. Often
4. Always
7. Resident declines to respond
8. Resident unable to respond

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Data Set Changes: Section D

Current D0100
MDS 3.0 v1.18.11
(ND)

Item revised: Completion instructions modified to:
If A0310G = 2, skip to E0100.

Revised D0100
MDS 3.0 v1.19.1
(ND)

D0100. Should Resident Mood Interview be Conducted?

If A0310G = 2 Skip to D0700. Otherwise, attempt to conduct interview with all residents.

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©)

D0100. Should Resident Mood Interview be Conducted?

If A0310G = 2, skip to E0100. Otherwise, attempt to conduct interview with all residents.

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©)

Data Set Changes: Section GG

Current GG Title
MDS 3.0 v1.18.11
(NC, NQ, ND, NPE, NP, IPA, SP, SD)

Section GG - Functional Abilities and Goals - Admission

Section title revised to:
Functional Abilities

Revised GG Title
MDS 3.0 v1.19.1
(NC, NQ, ND, NPE, NP, IPA, SP, SD)

Section GG - Functional Abilities - Admission

Data Set Changes: Section GG

Current GG 0100
MDS 3.0 v1.18.11
(NP)

Item revised: Language deleted from completion instructions: Complete only if A0310B = 01

Revised GG 0100
MDS 3.0 v1.19.1
(NP)

Section GG - Functional Abilities and Goals

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding:

3. **Independent** - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete any activities.
1. **Dependent** - A helper completed all the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

Enter Codes in Boxes

A. **Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.

B. **Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

C. **Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

D. **Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Section GG - Functional Abilities

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury

Coding:

3. **Independent** - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete any activities.
1. **Dependent** - A helper completed all the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

Enter Codes in Boxes

A. **Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.

B. **Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

C. **Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

D. **Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Data Set Changes: Section GG

Current GG 0110
MDS 3.0 v1.18.11
(NP)

Item revised: Language deleted from completion instructions: Complete only if A0310B = 01

Revised GG 0110
MDS 3.0 v1.19.1
(NP)

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Check all that apply

☐	A.	Manual wheelchair
☐	B.	Motorized wheelchair and/or scooter
☐	C.	Mechanical lift
☐	D.	Walker
☐	E.	Orthotics/Prosthetics
☐	Z.	None of the above

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury

Check all that apply

☐	A.	Manual wheelchair
☐	B.	Motorized wheelchair and/or scooter
☐	C.	Mechanical lift
☐	D.	Walker
☐	E.	Orthotics/Prosthetics
☐	Z.	None of the above

Data Set Changes: Section GG

Current GG 0130/0170 MDS 3.0 v1.18.11

Item revised: Completion instructions modified to: Complete column 1 when A0310A = 01 or when A0310B = 01. (NC only)

Column 2 retired (NC, NQ, NP, SP)

Section GG - Functional Abilities and Goals - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

	1. Admission Performance	2. Discharge Goal
	Enter Codes in Boxes ↓	↓
A.	☐☐	☐☐
B.	☐☐	☐☐

A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

Revised GG130/0170 MDS 3.0 v1.19.1

Section GG - Functional Abilities - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

	1. Admission Performance
	Enter Codes in Boxes ↓
A.	☐☐
B.	☐☐

A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

Data Set Changes: Section GG

Current GG 0130/0170 MDS 3.0 v1.18.11

(NQ)

Item revised: Completion instructions modified to: Complete column 1 when A0310B = 01.

Section GG - Functional Abilities and Goals - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Revised GG 0130/0170 MDS 3.0 v1.19.1

(NQ)

Section GG - Functional Abilities - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Data Set Changes: Section GG

Current GG 0130/0170
MDS 3.0 v1.18.11
(NP, SP)

Item revised: Completion instructions modified to: The stay begins on A2400B.

Revised GG 0130/0170
MDS 3.0 v1.19.1
(NP, SP)

Section GG - Functional Abilities and Goals - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600

Section GG - Functional Abilities - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
The stay begins on A2400B.

Data Set Changes: Section GG

Current GG 0130/0170 MDS 3.0 v1.18.11

(NC, NQ, NP, SP)

Item revised: Coding instructions modified to:

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Section GG - Functional Abilities and Goals - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Revised GG 0130/0170 MDS 3.0 v1.19.1

(NC, NQ, NP, SP)

Section GG - Functional Abilities - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Data Set Changes: Section GG

Current GG 0130/0170
MDS 3.0 v1.18.11
(ND, NPE, NP, SP, SD)

Item revised: Language deleted from completion instructions: A0310G is not = 2 and A0310H = 1 and

Revised GG 0130/0170
MDS 3.0 v1.19.1
(ND, NPE, NP, SP, SD)

Section GG - Functional Abilities and Goals - Discharge

GG0130. Self-Care (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Section GG - Functional Abilities - Discharge

GG0130. Self-Care (Assessment period is the last 3 days of the stay)
When A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Data Set Changes: Section GG

Current GG 0130/0170
MDS 3.0 v1.18.11
(NC, NQ)

Item revised: Language deleted from completion instructions: A0310G is not = 2 and

Revised GG 0130/0170
MDS 3.0 v1.19.1
(NC, NQ)

Section GG - Functional Abilities and Goals - Discharge

GG0130. Self-Care (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Section GG - Functional Abilities - Discharge

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

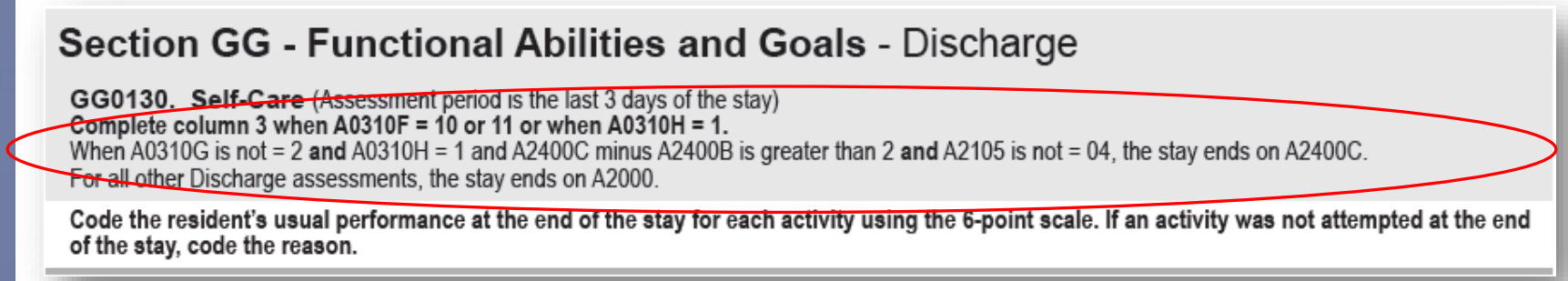
Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Data Set Changes: Section GG

Current GG 0130/0170
MDS 3.0 v1.18.11
(ND)

Item revised: Language deleted from completion instructions: Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.

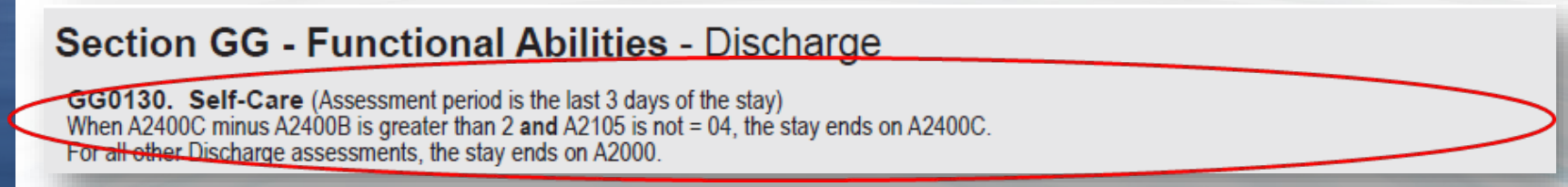
Revised GG 0130/0170
MDS 3.0 v1.19.1
(ND)



Section GG - Functional Abilities and Goals - Discharge

GG0130. Self-Care (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.



Section GG - Functional Abilities - Discharge

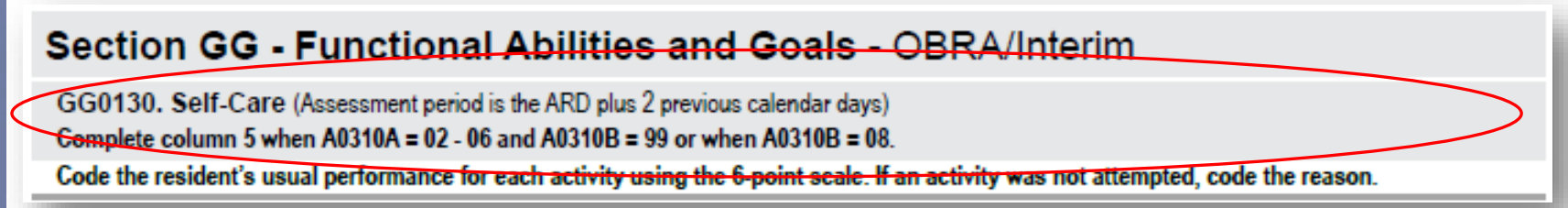
GG0130. Self-Care (Assessment period is the last 3 days of the stay)
When A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

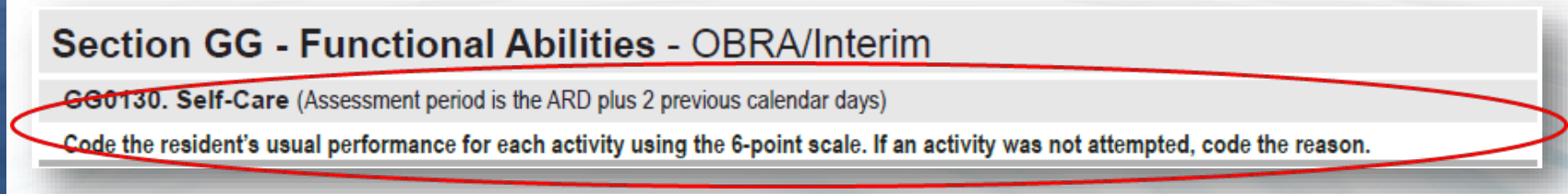
Data Set Changes: Section GG

Current GG 01300170
MDS 3.0 v1.18.11
(IPA)

Item revised: Language deleted from completion instructions: Complete column 5 when A0310A = 02 – 06 and A0310B = 99 or when A0310B = 08.

Revised GG 0130/1070
MDS 3.0 v1.19.1
(IPA)





Data Set Changes: Section GG

Current GG 0130/0170
MDS 3.0 v1.18.11
(NC, NQ)

Item revised: Language deleted from completion instructions: or when A0310B = 08

Revised GG 0130/0170
MDS 3.0 v1.19.1
(NC, NQ)

Section GG - Functional Abilities and Goals - OBRA/Interim

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)

~~Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.~~

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Section GG - Functional Abilities - OBRA/Interim

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)

~~Complete column 5 when A0310A = 02 - 06 and A0310B = 99.~~

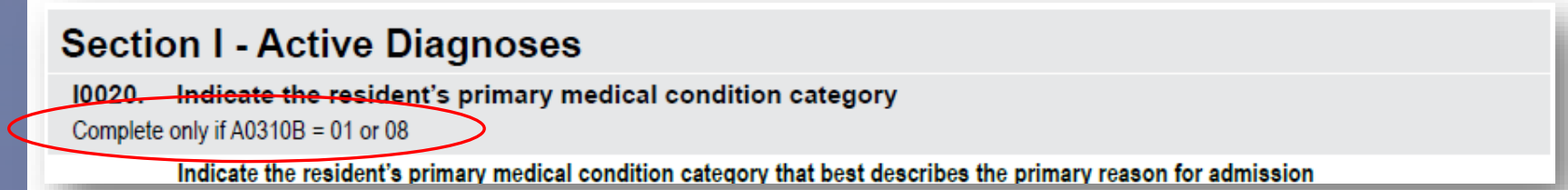
Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Data Set Changes: Section GG

Current I0020
MDS 3.0 v1.18.11
(NP, SP)

Completion instructions deleted.

Revised I0020
MDS 3.0 v1.19.1
(NP, SP)

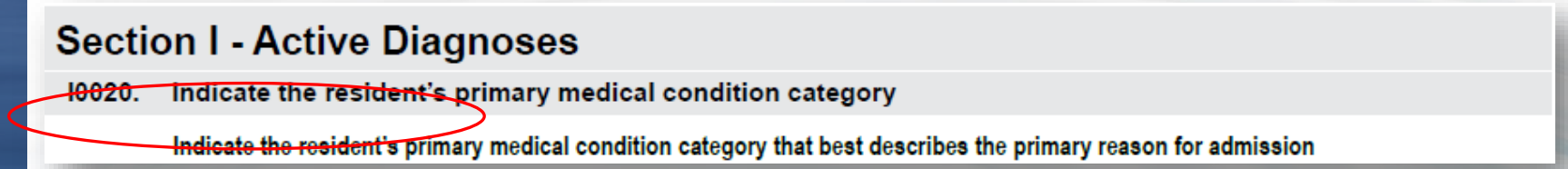


Section I - Active Diagnoses

I0020. ~~Indicate the resident's~~ primary medical condition category

Complete only if A0310B = 01 or 08

Indicate the resident's primary medical condition category that best describes the primary reason for admission



Section I - Active Diagnoses

I0020. Indicate the resident's primary medical condition category

~~Indicate the resident~~'s primary medical condition category that best describes the primary reason for admission

Data Set Changes: Section GG

Current J0200 MDS 3.0 v1.18.11

(NPE)

Item revised: Language deleted from completion instructions: J0200 If resident is comatose or A0310G=2, skip to J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled J2000 PPS). Otherwise, attempt to conduct interview with all residents.

Section J - Health Conditions

J0200. Should Pain Assessment Interview be Conducted?

~~Attempt to conduct interview with all residents. If resident is comatose or if A0310G = 2, skip to J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS). Otherwise, attempt to conduct interview with all residents.~~

Revised J0200 MDS 3.0 v1.19.1

(NPE)

Section J - Health Conditions

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents.

Data Set Changes: Section GG

Current J2000
MDS 3.0 v1.18.11
(NPE)

Item revised: Completion instructions deleted.

Revised J2000
MDS 3.0 v1.19.1
(NPE)

J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code ☐

Did the resident have major surgery during the **100 days prior to admission?**

0. **No**
1. **Yes**
8. **Unknown**

J2000. Prior Surgery

Enter Code ☐

Did the resident have major surgery during the **100 days prior to admission?**

0. **No**
1. **Yes**
8. **Unknown**

Data Set Changes: Section GG

Current J2100
MDS 3.0 v1.18.11
(NPE)

Item revised: Completion instructions deleted.

Revised J2100
MDS 3.0 v1.19.1
(NPE)

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08

Enter Code ☐

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

0. **No**
1. **Yes**
8. **Unknown**

J2100. Recent Surgery Requiring Active SNF Care

Enter Code ☐

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

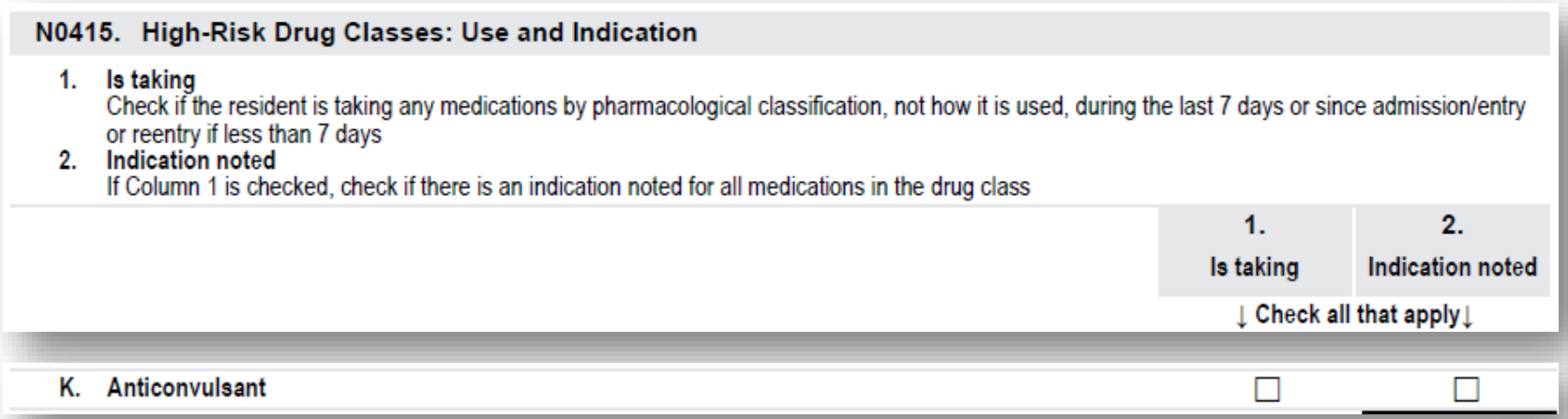
0. **No**
1. **Yes**
8. **Unknown**

Data Set Changes: Section GG

New subitem and responses added:

K. Anticonvulsant [with boxes for column 1 (Is taking) and 2 (Indication noted)]

Revised N0415K
MDS 3.0 v1.19.1
(NC, NQ, ND, NPE, NP, SP, SD)



N0415. High-Risk Drug Classes: Use and Indication

1. **Is taking**
   Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is taking	2. Indication noted
	↓ Check all that apply ↓	
K. Anticonvulsant	☐	☐

Page N-8 (Revised RAI User's Manual October 2024)

N0415K1. Anticonvulsant: *Check if an anticonvulsant medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).*

N0415K2. Anticonvulsant: *Check if there is an indication noted for all anticonvulsant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).*

Data Set Changes: Section GG

Current N2001
MDS 3.0 v1.18.11
(NP, SP)

Item revised: Completion instructions deleted.

Revised N2001
MDS 3.0 v1.19.1
(NP, SP)

N2001. Drug Regimen Review - Complete only if A0310B = 01

Did a complete drug regimen review identify potential clinically significant medication issues?

Enter Code ☐

0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

N2001. Drug Regimen Review

Did a complete drug regimen review identify potential clinically significant medication issues?

Enter Code ☐

0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

Data Set Changes: Section GG

Current N2005
MDS 3.0 v1.18.11
(NPE)

Item revised: Completion instructions deleted.

Revised N2005
MDS 3.0 v1.19.1
(NPE)

N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code ☐

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. **No**
1. **Yes**
9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

N2005. Medication Intervention

Enter Code ☐

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. **No**
1. **Yes**
9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

Data Set Changes: Section GG

Current O0300A1 MDS 3.0 v1.18.11

(NC, NQ, ND, NP, SP, SD)

Item revised: Skip pattern for option 1 modified to: 1. Yes → Skip to O0350, Resident's COVID-19 vaccination is up to date.

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?

0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0400, Therapies

Revised O0300A1 MDS 3.0 v1.19.1

(NC, NQ, ND, NP, SP, SD)

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?

0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0350, Resident's COVID-19 vaccination is up to date

Data Set Changes: Section GG

New item and responses added:

New item and responses added: O0350. Resident's COVID-19 vaccination is up to date 0. No, resident is not up to date 1. Yes, resident is up to date

Revised O0350
MDS 3.0 v1.19.1
(NC, NQ, ND, NPE, NP, SP, SD)

Section O - Special Treatments, Procedures, and Programs

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

Page O-20 (Revised RAI User's Manual October 2024)

Steps for Assessment

Vaccination status may be determined based on information from any available source. Review the resident's medical record or documentation of COVID-19 vaccination and/or interview the resident, family or other caregivers or healthcare providers to determine whether the resident is up to date with their COVID-19 vaccine.

*If the resident is **not up to date**, and the facility has the vaccine available, ask the resident if they would like to receive the COVID-19 vaccine.*

Data Set Changes: Section GG

New item and responses added:

New item and responses added: O0350. Resident's COVID-19 vaccination is up to date 0. No, resident is not up to date 1. Yes, resident is up to date

Revised O0350
MDS 3.0 v1.19.1
(NC, NQ, ND, NPE, NP, SP, SD)

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 residents 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.

DEFINITION: UP TO DATE for COVID-19 Vaccine
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-up-to-date.html.

Data Set Changes: Section GG

Current O0425
MDS 3.0 v1.18.11
(NPE)

Item revised: Completion instructions deleted.

Revised O0425
MDS 3.0 v1.19.1
(NPE)

Section O - Special Treatments, Procedures, and Programs

O0425. Part A Therapies

Complete only if A0310H = 1

Section O - Special Treatments, Procedures, and Programs

O0425. Part A Therapies

Data Set Changes: Section GG

Current O0430
MDS 3.0 v1.18.11
(NPE)

Item revised: Completion instructions deleted.

Revised O0430
MDS 3.0 v1.19.1
(NPE)

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

Enter Number of Days ☐☐☐

Record the number of **calendar days** that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes since the start date of the resident's most recent Medicare Part A stay (A2400B)

O0430. Distinct Calendar Days of Part A Therapy

Enter Number of Days ☐☐☐

Record the number of **calendar days** that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes since the start date of the resident's most recent Medicare Part A stay (A2400B)

Notable RAI Manual Revisions v1.19.1

Data Set Changes: Section GG

- **Section A** Pages A-45 and A-47 – **A2121Provision of Current Reconciled Medication List to Subsequent Provider at Discharge**: Instructions and examples for coding this item when the resident remains in the nursing facility have been removed. (See slides 11 and 12)
- **Section C** Page C-17 – Coding tips for C0500 have been revised to add the following guidance: *"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**
  - References and coding instructions related to discharge goals have been removed throughout the chapter.
  - Page GG-32 Personal hygiene example 2 has been revised to be more specific related to substantial maximal coding.

Notable RAI Manual Revisions v1.19.1

Data Set Changes: Section GG

- **Section GG (Cont.)**
  - Pages GG-61 and GG-62 guidance has been added to clarify coding items GG0170M, 1 step (curb); GG0170N, 4 steps; and GG0170O, 12 steps. Specifically:
    - *If, at the time of the assessment, a resident is unable to complete the activity because of a physician-prescribed restriction (of no stair) 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.*
    - *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.*
    - *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.*

Notable RAI Manual Revisions v1.19.1

Data Set Changes: Section GG

- **Section H** Pages H-2 and H-3 the definition of External catheter has been revised to include, *"…a female external catheter, or other non-invasive urine output management device or system that routes urine."* and coding tips have been added, *"Female external catheters and other non-invasive urine output management devices or systems should be coded as external catheters (H0100B)."*
- **Section I** on page I-13 a clarification has been added related to coding 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."*

Notable RAI Manual Revisions v1.19.1

Data Set Changes: Section GG

- **Section K**
  - Page K-10, the word “medication” has been removed from the definition of tube feeding. ***FEEDING TUBE****: Presence of any type of tube that can deliver food/ nutritional substances/ fluids/ ~~medications~~ directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.*
  - Page K-12, the word “or” has been added to the clarification for coding IV fluids, “*IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and/or hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.”*
- **Section N** PageN-8 has been revised to add coding guidelines for new item N0415K1 Anticonvulsants. (See slide 32.)

Notable RAI Manual Revisions v1.19.1

Data Set Changes: Section GG

- **Section O**
  - Page O-9 has been updated to include additional clarification for the definition of item O0110O1, IV Access with the following, *"An arteriovenous (AV) fistula does not meet the definition of IV Access for O0110O1."*
  - Pages O-16 through O-18 have been revised to include revisions/clarifications to the examples for coding item O0300A, Is the Resident's Pneumococcal Vaccination Up to Date?
  - On pages O-19 through O-20 coding guidance has been added for new MDS item O0350, Resident's COVID-19 vaccination is up to date. (See also slides 36-37.)
  - **Section X** Pages X-1 and X-2 have been revised to include new guidance on an additional instance when a Manual Deletion request is required.
    - ***Record submitted was not for OBRA or Medicare Part A purposes.*** *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 included in the record, and a manual deletion is required to remove it from the CMS database. For erroneous PPS assessments combined with OBRA-required assessments, if the item set code changes, the assessment must be manually deleted, and a new, stand-alone OBRA assessment must be submitted. If the item set code does not change, then a modification can be completed.*

Notable RAI Manual Revisions v1.19.1

Data Set Changes: Section GG

- **Chapter 5**
  - Page 5-14 has been revised to further elaborate on the section X additions.
    - *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.*
- **Appendix A** has been revised to include definitions for Female External Catheter (see slide 42) , Indication for medication use and Up to Date for COVID-19 vaccine (see slide 37) .
- **Appendix B** continues to be a separate download and was updated in August 2024.

Notable RAI Manual Revisions v1.19.1

Data Set Changes: Section GG

- **Appendix C** CAA 8, Mood State, and CAA 15, Dental Care, have been revised to include item N0415K, Anticonvulsants, under review of medications.
- **Appendix F** has been removed from the PDF files included in the RAI manual file downloads and is included in a separate downloadable file in the downloads section of the CMS RAI Manual page. It has been reformatted and revised to include the new MDS items added in FY 2025.
- **MDS 3.0 RAI User's Manual (v1.19.1R) Hyperlink Update Supplement v1 Effective October 01, 2024**
  - Purpose Due to external webpage changes, hyperlinks (links) may occasionally redirect, become unreachable, or the information provided on the webpage may change. This document serves as a supplementary list of links in the MDS 3.0 RAI User's Manual version (v)1.19.1 that require updates as identified throughout the lifetime of the document. Replacement pages for each affected page can be found following the list. Updated pages of the RAI Manual can also be found in this download.

SNF QRP Updates

Current SNF QRP Measures:

In this rule, CMS is not adopting any new measures for the SNF QRP.

TABLE 28: Quality Measures Currently Adopted for the SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
TOH-Provider	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC)
TOH-Patient	Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC)
DC Function	Discharge Function Score
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
National Healthcare Safety Network	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

SNF QRP Updates – New MDS Items

- CMS has finalized a requirement to require SNFs to collect and submit four new items in the MDS as standardized patient assessment data elements under the SDOH category because these items would collect information not already captured by the current SDOH items.
- CMS believes the ongoing identification of SDOH would have three significant benefits.
  - First, promoting screening for these SDOH could serve as evidence-based building blocks for supporting healthcare providers in actualizing their commitment to address **disparities that disproportionately impact underserved communities**.
  - Second, screening for SDOH **improves health equity** through identifying potential social needs so the SNF may address those with the resident, their caregivers, and community partners during the discharge planning process, if indicated.
  - Third, these SDOH items could support CMS' ongoing SNF QRP initiatives by providing data with which to **stratify SNF's performance on measures and or in future quality measures**.

SNF QRP Updates – New MDS Items

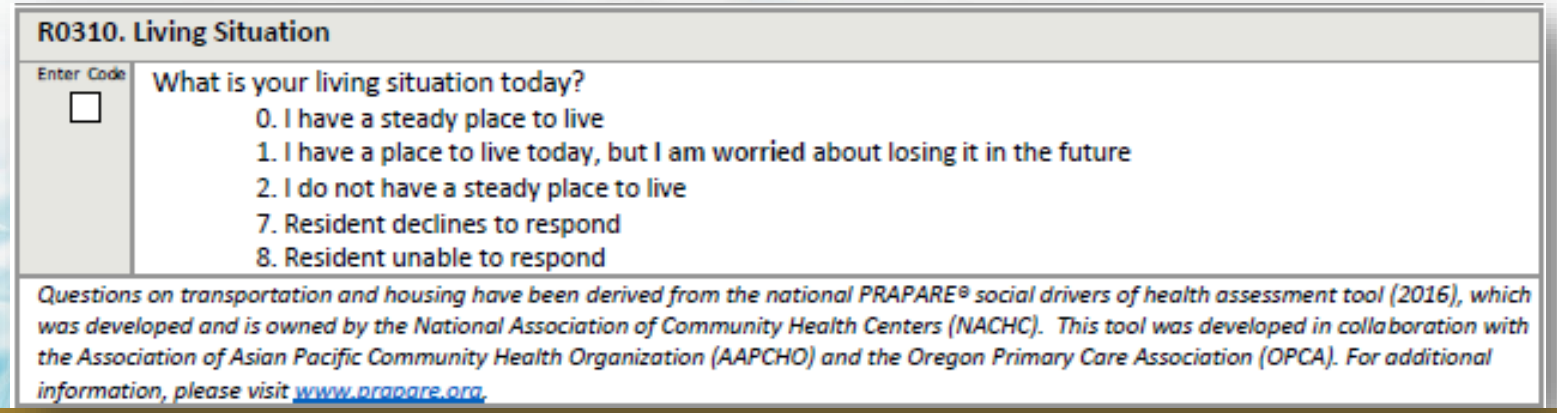
- CMS' definition of SDOH: SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- According to the World Health Organization, research shows that the SDOH can be more important than health care or lifestyle choices in influencing health, accounting for between 30 to 55 percent of health outcomes.
- Access to standardized data relating to SDOH on a national level permits us to conduct periodic analyses, and to assess their appropriateness as risk adjustors or in future quality measures.
- These items have the capacity to take into account treatment preferences and care goals of residents and their caregivers, to inform CMS' understanding of resident complexity and SDOH **that may affect care outcomes and ensure that SNFs are in a position to impact them through the provision of services and supports**, such as connecting residents and their caregivers with identified needs with social support programs.

SNF QRP Updates – New MDS Items

- **Health-related social needs (HRSNs)** are individual-level, adverse social conditions that negatively impact a person's health or health care, and are the resulting effects of SDOH.
- Examples of HRSNs include lack of access to food, housing, or transportation, and have been associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs.
- Certain HRSNs can directly influence an individual's physical, psychosocial, and functional status. This is particularly true for **food security, housing stability, utilities security, and access to transportation**.
- Additional collection of SDOH items would permit CMS to continue developing the statistical tools necessary to maximize the value of Medicare data and improve the quality of care for all beneficiaries.
- As CMS continues to standardize data collection across PAC settings, they believe using common standards and definitions for new items is important to promote interoperable exchange of longitudinal information between SNFs and other providers to **facilitate coordinated care, continuity in care planning, and the discharge planning process**.

SNF QRP Updates – New MDS Items

- **Living Situation**
  - Lack of housing stability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing.
  - These experiences may negatively affect one's physical health and access to health care.
  - Housing instability can also lead to homelessness, which is housing deprivation in its most severe form. People who are homeless have an increased risk of premature death and experience chronic disease more often than among the general population
  - CMS believes that SNFs can use information obtained from the Living Situation item during a resident's discharge planning.
  - Due to the potential negative impacts housing instability can have on a resident's health, CMS is adopting the Living Situation item as a new standardized patient assessment data element under the SDOH category.



R0310. Living Situation

Enter Code ☐

What is your living situation today?

0. I have a steady place to live
1. I have a place to live today, but I am worried about losing it in the future
2. I do not have a steady place to live
7. Resident declines to respond
8. Resident unable to respond

Questions on transportation and housing have been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.nrapare.org.

SNF QRP Updates – New MDS Items

- **Food (2 items)**
  - The U.S. Department of Agriculture, Economic Research Service defines a lack of food security as a household-level economic and social condition of limited or uncertain access to adequate food.
  - Adults who are food insecure may be at an increased risk for a variety of negative health outcomes and health disparities like obesity, and higher probability of death from any cause or cardiovascular disease.
  - Having enough food is one of many predictors for health outcomes, a diet low in nutritious foods is also a factor.
  - CMS believes that adopting items to collect and analyze information about a resident's food security at home could provide additional insight to their health complexity and help facilitate coordination with other healthcare providers, facilities, and agencies during transitions of care, so that referrals to address a resident's food security are not lost during vulnerable transition periods.
  - CMS is adopting two Food items as new standardized patient assessment data elements under the SDOH category.

SNF QRP Updates – New MDS Items

- **Food (2 items) cont.**

R0320. Food

Enter Code ☐

A. Within the past 12 months, you worried that your food would run out before you got money to buy more.
- 0. Often true
- 1. Sometimes true
- 2. Never true
- 7. Resident declines to respond
- 8. Resident unable to respond

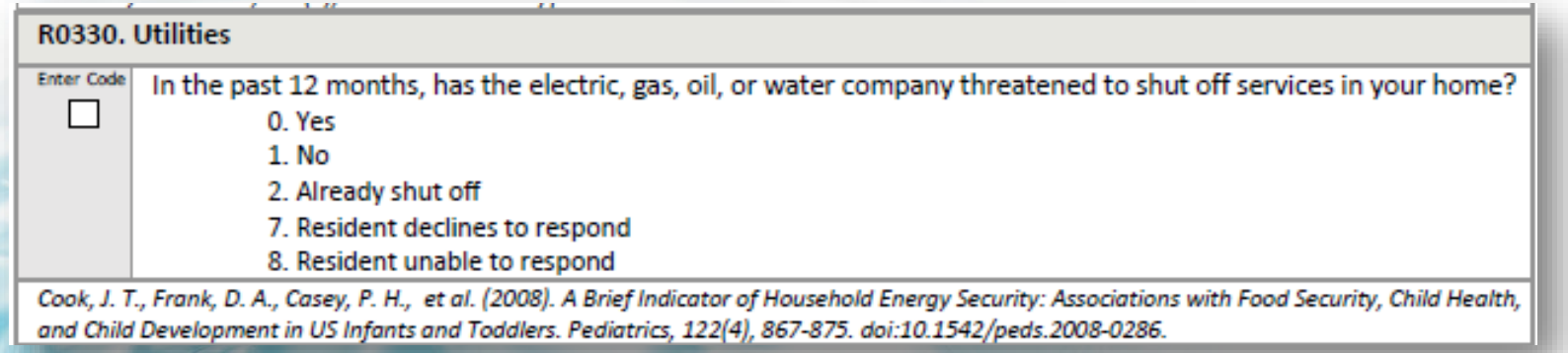
Enter Code ☐

B. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
- 0. Often true
- 1. Sometimes true
- 2. Never true
- 7. Resident declines to respond
- 8. Resident unable to respond

Hager, E. R., Quigg, A. M., Black, M. M., et al. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.

SNF QRP Updates – New MDS Items

- **Utilities**
  - A lack of energy (utility) security can be defined as an inability to adequately meet basic household energy needs. According to the United States Department of Energy, one in three households in the U.S. are unable to adequately meet basic household energy needs.
  - The consequences associated with a lack of utility security are represented by three primary dimensions: economic; physical; and behavioral. The effects of a lack of utility security include vulnerability to environmental exposures such as dampness, mold, and thermal discomfort in the home, which have a direct impact on a person's health.
  - CMS believes that adopting an item to collect information about a resident's utility security would facilitate the identification of residents who may not have utility security and who may benefit from engagement efforts.
  - CMS is adopting a new item, Utilities, as a new standardized patient assessment data element under the SDOH category



R0330. Utilities

Enter Code ☐

In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

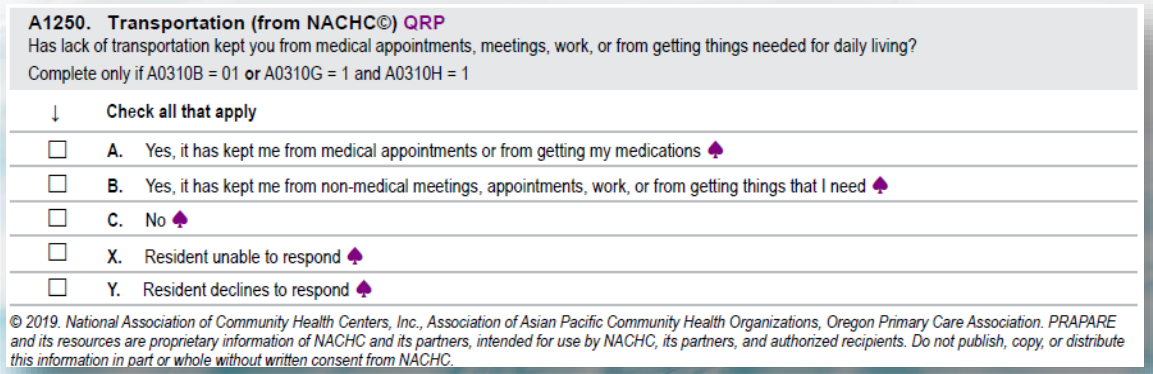
0. Yes
1. No
2. Already shut off
7. Resident declines to respond
8. Resident unable to respond

Cook, J. T., Frank, D. A., Casey, P. H., et al. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286.

SNF QRP Updates – New MDS Items

- **Transportation (Revised)**
  - Beginning October 1, 2023, SNFs began collecting seven items adopted as standardized patient assessment data elements under the SDOH category on the MDS. One of these items, A1250. Transportation, collects data on whether a lack of transportation has kept a resident from getting to and from medical appointments, meetings, work, or from getting things they need for daily living.
  - First, the modification of the Transportation item will use a defined 12-month look back period, while the current Transportation item uses a look back period of 6 to 12 months. CMS believes the distinction of a 12-month look back period would reduce ambiguity for both residents and clinicians, and therefore, improve the validity of the data collected.
  - Second, CMS will simplify the response options, as shown below, as they believe reliable transportation services are fundamental to a person's overall health, and as a result, the burden of collecting this information separately outweighs its potential benefit.

Current



A1250. Transportation (from NACHC©) QRP

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓	Check all that apply
☐	A. Yes, it has kept me from medical appointments or from getting my medications ♠
☐	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need ♠
☐	C. No ♠
☐	X. Resident unable to respond ♠
☐	Y. Resident declines to respond ♠

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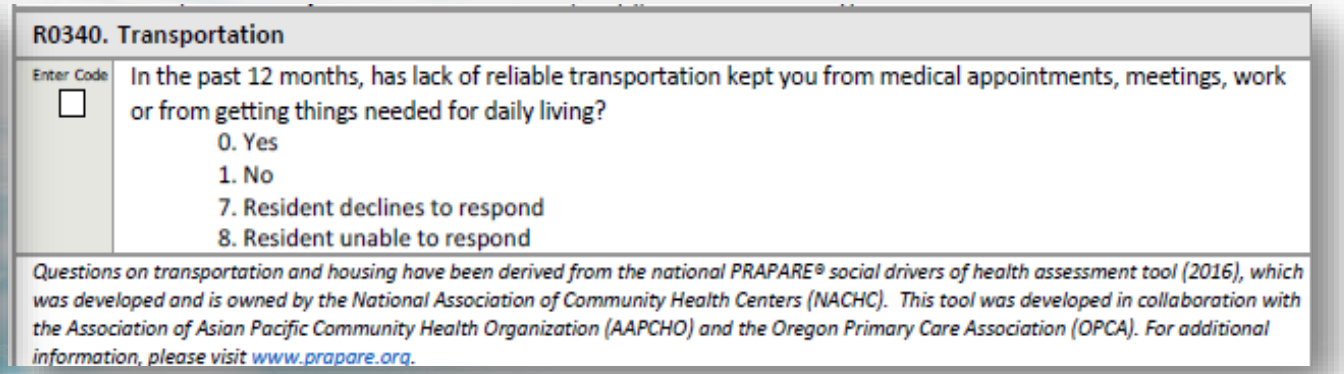
Finalized



R0340. Transportation

Enter Code ☐

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

0. Yes
1. No
7. Resident declines to respond
8. Resident unable to respond

Questions on transportation and housing have been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.prapare.org.

SNF QRP Updates – New MDS Items Timing

- SNFs will be required to report these new items and the modified Transportation item using the MDS beginning with residents admitted on October 1, 2025 through December 31, 2025 for purposes of the FY 2027 SNF QRP.
- Starting in CY 2026, SNFs would be required to submit data for the entire calendar year for each program year.
- Data collection will **exclude any SNF residents who, immediately prior to their hospitalization that preceded a new SNF stay, resided in a NF for at least 366 continuous days.**
- SNFs will be required to submit the Living Situation, Food, and Utilities items as standardized patient assessment data elements under the SDOH category at admission only (and not at discharge) because it is unlikely that the assessment of those items at admission would differ from the assessment of the same item at discharge.
- SNFs will also collect and submit the modified standardized patient assessment data element, Transportation, at admission only.

Removal of MDS Items

- As outlined in the FY 2019 SNF PPS final rule several MDS items are not needed in case-mix adjusting the per diem payment for PDPM. However, they were not accounted for in the FY 2019 SNF PPS final rule.
- Therefore, CMS is removing all O0400 A, B, C and E Therapies items from the 5-day Medicare required assessment beginning October 1, 2025.

QUESTIONS?