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MDS 3.0 RAI Updates 10-2025

September 17, 2025

Will begin at 1:00 pm

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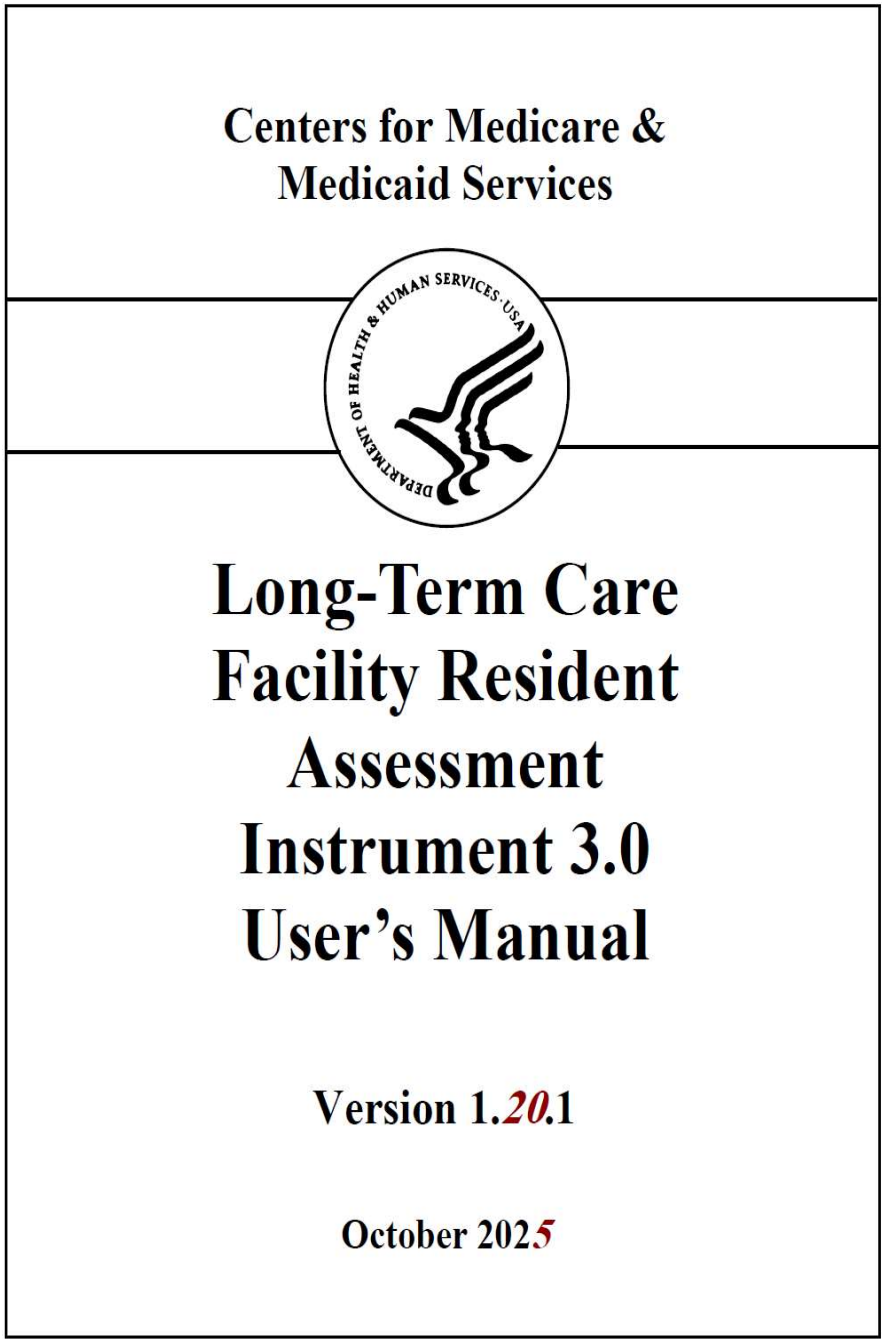
Final MDS 3.0 RAI Manual Released August 29, 2025

https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

Change tables are on page 863 - 1001



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General Changes

- Various minor alignments, clarifications and corrections throughout the manual

Section A: Identification Information

- "Gender" was changed to "Sex" in multiple areas of this section

- A1005 (Ethnicity)
  - Several elements in the Item Rationale section were removed, which spoke to the reason why the data was being collected, and the source for the categories.
  - The Rationale section now simply states that this data is an important step in improving quality of care and health outcomes across multiple healthcare settings
  - An example to assist with framing of the question was removed.

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Section A: Identification Information

- A1010 (Race)
  - The changes are mislabeled in the CMS tables as "A1005."
  - Several elements in the Item Rationale section were removed, which spoke to the reason why the data was being collected, and the source for the categories.
  - The Rationale section now simply states that this information allows for the equal comparison of data across multiple healthcare settings
  - An example to assist with framing of the question was removed.

Section A: Identification Information

- A1255 (Transportation)
  - A1250 was replaced with a new item, A1255.

A1255. Transportation

Complete only if A0310B = 01 and A2300 minus A1900 is less than 366 days

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

  - Clarification that the transportation items were derived from the national PRAPARE social drivers of health assessment tool
  - Only completed if A0310B = 01 AND A2300 minus A1900 is less than 366 days

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Section A: Identification Information

- A1255 (Transportation)
  - New interview question:

    "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"
  - Previous interview items were combined and now the resident will only need to respond one time.
  - References to a lack of transportation have been clarified to a "lack of reliable transportation."
  - CMS clarifies that a dash value should be rare
  - Clarifying example provided indicating that if neither the resident, their family, significant other, or legally authorized representative was able to provide a response, but the medical record documentation provided the necessary information, code the information and do not code "X" (Resident unable to respond)

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Section D: Mood

- D0150 (Resident Mood Interview PHQ2-9)
  - Clarifies that if the resident cannot provide a frequency, a dash may be used, but this should be rare.
  - Clarifies that if D0150A2 through D0150I2 is blank or dashed for 3 or more items, the interview is deemed not complete. The Total Severity Score should be coded as "99", and do NOT complete the Staff Assessment Mood.

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Section F: Preferences for Customary Routine and Activities

- Minor page numbering references were clarified.

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Section GG: Functional Abilities

- GG0100
  - Some examples were removed from the manual, reducing duplication, but the overall guidance remains the same.
- GG0100C (Stair Activity)
  - Clarifies that "by any safe means" may include a resident scooting up and down stairs on their buttocks.
- GG0110 (Prior Device Use)
  - Clarifies that clinical judgment may be used to determine whether other devices meet the definition provided
- GG0130 (Self-Care) and GG0170 (Mobility)
  - Clarifies that the definition of a helper applies to these sections.

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Section GG: Functional Abilities

- GG0130 (Self-Care) and GG0170 (Mobility)
  - Many coding tips were added:
    - Assessment of GG self-care and mobility items is based on the resident's ability to complete the activity with or without assistance and/or a device.
      - This is true regardless of whether or not the activity is being/will be routinely performed
      - You can still attempt to assess the resident's ability, even if they don't routinely use the skill.
    - Clarifies that during the assessment timeframe (up to 3 calendar days based on the target date), some activities may be performed by the resident multiple times, whereas other activities may only occur once.

Section GG: Functional Abilities

- GG0130 (Self-Care) and GG0170 (Mobility)
  - Many coding tips were added:
    - Clarifies that coding of a dash should be a rare occurrence
    - Clinical assessment may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible
      - Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g. parallel bars, exoskeleton, or overhead track and harness systems)
    - When coding usual performance, if two or more helpers are required to assist the resident in completing the activity, code as 01 (Dependent.)
    - The adequacy of the resident's nutrition or hydration is not considered for GG0130A (Eating.)

Section GG: Functional Abilities

- GG0130 (Self-Care) and GG0170 (Mobility)
  - Clarified that coding examples may describe a single observation of the resident completing the activity, or may describe a summary of several observations of the resident completing an activity across different times of the day and different days
  - Consider an item that covers all or part of the foot as footwear, even if it extends up the leg.
    - Do not also code this as a lower body dressing item.
  - If the resident wears just shoes or socks that are safe for mobility, then GG0130H (Putting on/taking off footwear), may be coded.

Section GG: Functional Abilities

- GG0170A (Roll left and right), GG0170F (Sit to lying), and GG0170C (Lying to sitting on the side of bed)
  - Use clinical judgement to determine what is considered a "lying" position for the resident. Example: a clinician could determine that a resident's preferred slightly elevated resting position is "lying" for a resident.

- GG0170E (Chair/bed-to-chair transfer)
  - If a resident uses a recliner as their "bed", assess the resident's need for assistance using that sleeping surface when coding GG0170E

Section GG: Functional Abilities

- GG170G (Car Transfer)
  - Any vehicle model appropriate and available may be used for the assessment
  - Clinical judgment may be used to determine if observing a resident performing a portion of the car transfer activity allows the clinician to adequately assess the resident's ability to complete the entire GG0170G, car transfer, and code based on the amount of assistance required.

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Section GG: Functional Abilities

- GG170 (Walking Activities)
  - Do not code walking activities with the use of a device that is restricted to resident use during therapy sessions
  - If the resident requires the assistance of two helpers to complete the activity, code 01 (Dependent).
  - If the only help a resident requires to complete the walking activity is for a helper to retrieve and place the walker and/or put it away after use, then enter code 05 (Setup or clean-up assistance.)
  - Getting to/from the stairs is not included when coding the curb/step activities.
  - Do not consider the sit-to-stand or stand-to-sit transfer when coding any of the step activities.

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Section I: Active Diagnoses

- Some minor numbering changing

Section J: Health Conditions

- The definition of a fall has changed to:

  Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat) or the result of an overwhelming external force (e.g., a resident pushes another resident.)

  An intercepted fall occurs when the resident would have fallen if they had not caught themself or had not been intercepted by another person – this is still considered a fall.

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Section J: Health Conditions

- Definition of a fall:
  - Some previous elements of the fall definition have been moved to coding tips:
    - Falls may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.
    - Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.
    - Challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and is not a fall.
      - NEW – However, if there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall.

Section J: Health Conditions

- Definition of Fall with Injury (Except Major) has changed to:

  Includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or an fall-related injury that causes the resident to complain of pain.

  - Very subjective
  - Careful….. The new language is not included on the final item sets.

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Section J: Health Conditions

- Definition of Fall with Major Injury has changed to:

  Includes, but is not limited to, traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries

  - Very subjective
  - Careful….. The new language is not included on the final item sets.
  - Will have a significant impact on Quality Measures and Ohio QIP

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Section J: Health Conditions

- J1900 (Number of Falls Since Admission/Entry or Reentry or Prior Assessment)
  - Clarifies that fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall.
  - Example included to demonstrate a fall that occurs during balance training with therapy

Differentiating from Traumatic vs. Pathological Fractures Examples

Resident A, who has osteoporosis, falls, resulting in a right hip fracture. The Emergency Department physician confirms that the fracture is a result of the resident's bone disease and not a result of the fall.
Coding: J1800 would be **coded 1, yes** and J1900C would be **coded 0, none**.

Rationale: The physician determined that the fracture was a pathological fracture due to osteoporosis. Because the fracture was determined to be pathological, it is not coded as a fall with major injury.

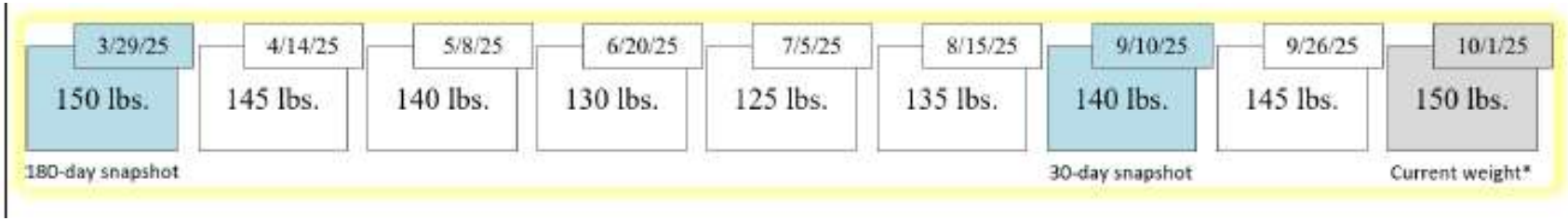
Resident L, who has osteoporosis, falls, resulting in a right hip fracture. The physician in the acute care hospital confirms that the fracture is a result of the resident's fall and not the resident's history of osteoporosis.
Coding: J1800 would be **coded 1, yes** and J1900C would be **coded 1, one**.

Rationale: Because the physician determined that the fracture was a result of the fall, it is a traumatic fracture and, therefore, is a fall with major injury.

Section K: Swallowing/Nutritional Status

- K0300 (Weight Loss) and K0310 (Weight Gain)
  - Clarification provided that the resident's weight captured closest to these two time points are the only two weights considered for this item
  - Although not considered on the MDS, communities should still monitor weight, and implement interventions as needed.
  - If multiple weights for the resident exist, select the weight on the date closest to the appropriate time point.
  - A qualified dietitian or other clinically qualified nutrition professional may now be consulted related to K0710 (Percent Intake by Artificial Route) if the resident had more substantial oral intake than sips of fluid.

- New Weight Comparison Examples



Example Based on ARD of 10/15/2025

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Section M: Skin Conditions

- M0300 (Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage)
  - Clarification that if a numerically stageable pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident's stay, the pressure ulcer/injury is coded at M0300F and should not be coded as "present on admission"
  - Clarification that if a pressure ulcer/injury was unstageable on admission/entry or reentry and then becomes unstageable for another reason, it should be considered "present on admission" at the new unstageable status

Section N: Medications

- N0415 (High-Risk Drug Classes: Use and Indication)
  - CMS indicates that facilities may wish to identify a resource that their staff consistently uses to identify pharmacological classification
    - Assessors should be able to identify the source(s) used to support coding the MDS 3.0
    - Language related to consulting resources/links cited in Section N have been removed.
  - Clarified that flushes to keep an IV access patent is not coded in N0415E (Anticoagulant)
  - Some grammatical changes

Section O: Special Treatment, Procedures, and Programs

- O0300 (Pneumococcal Vaccine)
  - CDC guidance about risk conditions can be found at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/risk-indications.html
  - Language to include PCV21 vaccines was added to the O0300 example
  - Additional examples were clarified based on CDC guidance

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Section O: Special Treatment, Procedures, and Programs

- O0390 (Therapy Services)
  - New item that replaces O0400 as it related to OT, PT, SLP, and Psychological Therapy days and minutes
  - If O0390D (Respiratory Therapy) is checked, then O0400D (Respiratory Therapy Days) must be completed.
    - All other aspects of O0400 were removed.

O0390.	Therapy Services Indicate therapies administered for at least 15 minutes a day on one or more days in the last 7 days
↓	Check all that apply
☐	A. Speech-Language Pathology and Audiology Services
☐	B. Occupational Therapy
☐	C. Physical Therapy
☐	D. Respiratory Therapy
☐	E. Psychological Therapy
☐	Z. None of the above

Section O: Special Treatment, Procedures, and Programs

- O0390 (Therapy Services)
  - CMS stresses the importance of maintaining as much independence as possible in ADLs, mobility and communication, and lists the possible risks of decline
  - CMS states that Rehabilitation Services can help residents attain or maintain their highest level of well-being and improve quality of life
  - Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were:
    1. Ordered by a physician (or extender) based on a qualified therapist's assessment and treatment plan
    2. Documented in the medical record
    3. Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective

Section O: Special Treatment, Procedures, and Programs

- O0390 (Therapy Services)
  - Coding Instructions
    - Check each therapy service that was administered for at least 15 minutes per day on one or more days in the last 7 days.
    - Check none of the above if the resident did not receive therapy services for at least 15 minutes per day on one or more days in the last 7 days.
    - A day of therapy is defined as skilled treatment for 15 or more minutes during the day.
    - It is not required that at least 15 minutes of a single mode of therapy is received to be checked on the MDS. Minutes from the same therapy discipline but different therapy modes (e.g., individual and concurrent) may be combined to meet the "at least 15 minutes" of skilled therapy in a day
    - Much of the coding instruction from the previous O0400 was transferred to O0390

Section O: Special Treatment, Procedures, and Programs

- O0390 (Therapy Services)
  - Recreational therapy is no longer coded on the MDS 3.0

- O0420 (Distinct Calendar Days of Therapy)
  - This section was removed from the MDS 3.0

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Section R: Social Determinants of Health

- The proposed Section R was removed.

Section X: Correction Request

- Clarified that the modification and inactivation processes do not remove the prior erroneous record from iQIES
  - The previous record remains in the database, but is archived
  - If it is necessary to delete or change a record and not retain any information about the record in iQIES, the facility must complete an MDS 3.0 Individual Correction Request or an MDS 3.0 Individual Deletion Request in iQIES
  - In situations in which the state-assigned facility submission ID (FAC_ID) or the state code (STATE_CD) is incorrect, an MDS 3.0 Manual Assessment Move Facility Request is required
  - Additional detail about the process can be found in Chapter 5 of the MDS Manual, and in the iQIES Assessment Management: Assessment Submitter Manual:

https://qtso.cms.gov/system/files/qtso/iQIES%20Assessment%20Management%20Manual%20for%20Assessment%20Submitter%20v2.1%20FINAL%2008.11.25_508.pdf

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Chapter 5 (Submission and Correction of the MDS Assessments)

- The term "Manual Assessment" or "Manual Deletion" has been replaced by "Individual Correction/Deletion or Move Request."

- Added a link to the iQIES MDS Error Messages Reference Guide:

https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals

- Establishes that errors resulting in the need for an MDS 3.0 Individual Correction/Deletion or Move Request must be corrected within 14 days after identifying the errors

Chapter 5 (Submission and Correction of the MDS Assessments)

- Further defines the process for an Individual Correction/Deletion or Move Request.
  - If a record was submitted either with an error in Item A0410, not for OBRA or Medicare Part A purposes, or as a test record, the facility must complete the proper request within iQIES.
  - The State Agency will review the request and either approve or reject the request. In some cases, the State Agency will return the request and ask for additional information
  - If the State Agency approves the request, the assessment is deleted from or corrected in the iQIES database.
  - Deleted records cannot be recovered
  - If the State Agency does not approve the request, the provider should address any concerns and, if appropriate, submit a new request

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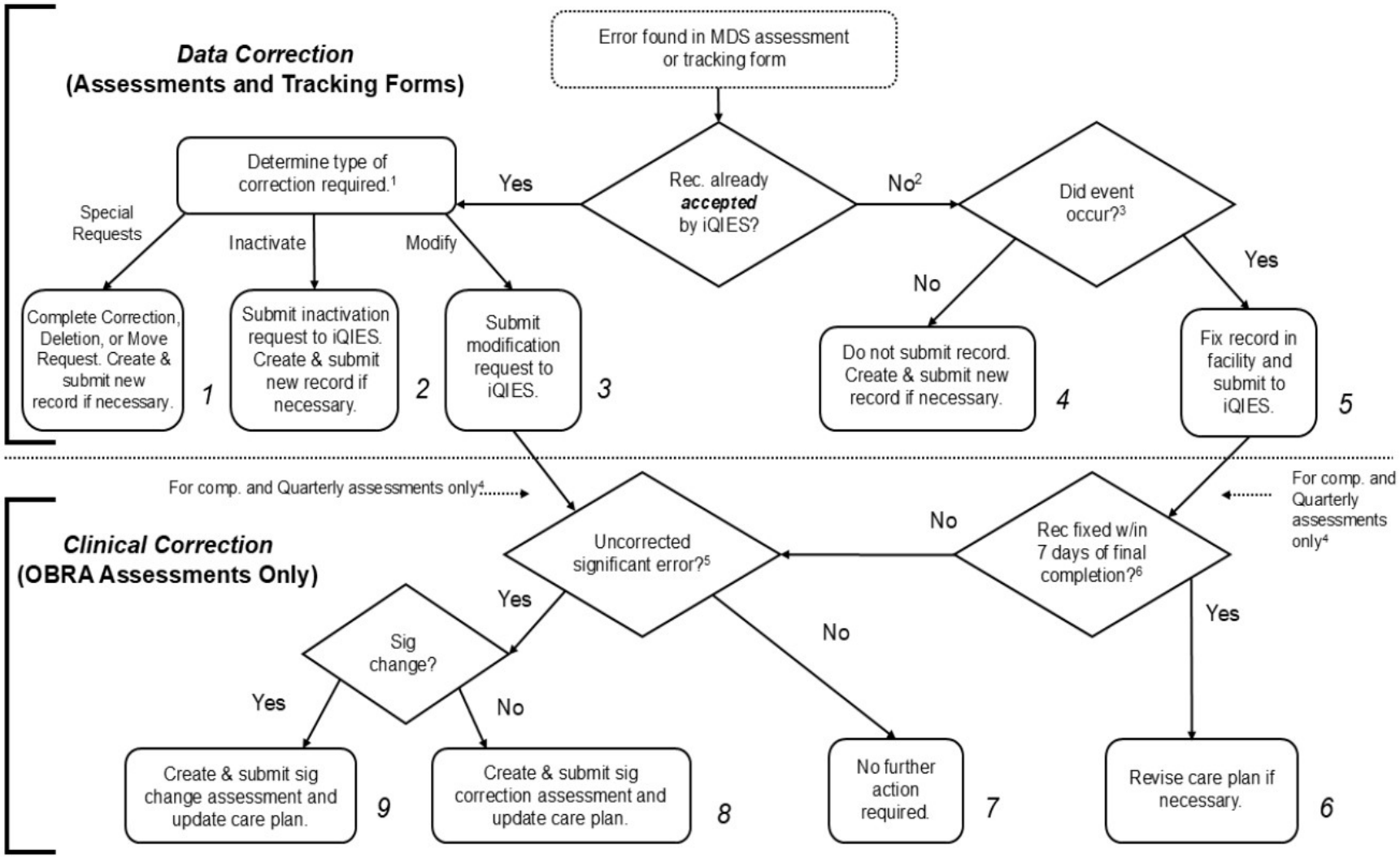
Chapter 5 (Submission and Correction of the MDS Assessments)

- In situations in which the state-assigned facility submission ID (FAC_ID) or the state code (STATE_CD) is incorrect, an MDS 3.0 Manual Assessment Move Facility Request is Required
  - The provider must complete and submit the form to the State Agency
  - Forms with Protected Health Information (PHI) must be sent via certified mail through the United States Postal Service
  - The State Agency will review the request and contact the facility if required.
  - After approving the request, the State Agency must sign the form and send it to the iQIES Help Desk

New Correction Decision Tree Available



Appendix A: Glossary

Several new definitions were added:

- Case Mix Hierarchy: A system that assigns case mix weights that capture differences in the relative resources used for treating different types of residents.
- Fall: Definition was updated as noted in previous slides
- Interim Payment Assessment (IPA): an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification
- Non-medication Pain Intervention: Now includes occupational therapy

Appendix A: Glossary

- Non-Therapy Ancillary (NTA): One of the five categories used to determine reimbursement under PDPM. NTA accounts for the non-therapy services and treatments a resident may need during their stay, such as medications, medical supplies and specialized treatments.
- Prior to the Benefit of Services: Prior to the provision of any care by facility staff that would result in more independent coding.
- Qualified Clinicians: Healthcare professionals practicing within their scope of practice and consistent with Federal, state, and local laws and regulations.

Appendix A: Glossary

- Quality Measures: Tools that help measure or quantify healthcare processes, outcomes, patient perceptions and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that related to one or more quality goals for health care. These goals include care that is: effective, safe, efficient, patient-centered, equitable and timely
- Total Parenteral Nutrition: A method of feeding that bypasses the gastrointestinal tract. A special formula given through a vein provides most of the nutrients the body needs.

Appendix C, Appendix F, Appendix G, Appendix H

- Multiple links to resources were updated

- The estimated average time to complete an NP item set was updated to 51 minutes

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Other Updates

- Long-Stay Antipsychotic Medication Quality Measure
- PDPM Transition
  - When will full PDPM implementation take place?
  - What weights will be used?
  - Will there be a conversion factor and what will it be?
- Preliminary Case Mix Reports
- Exception Reviews
- 5-Star Updates

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Would you like to learn more?

Please join us for a deeper dive into the MDS 3.0 changes exploring how they will impact provider operations, Quality Measures and QIP, as well as tips for implementation.

October 16, 2025 at 2:00 PM

For more information, please visit us on the EFOHCA webpage:

https://webinars.ohca.org/?pg=semwebCatalog&panel=showLive&seminarid=25779

Questions?

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