Track Changes
from Title Page v1.20.1
to Title Page v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
—	—	1	**Version 1.20.11**
—	—	1	**October 2025~~5~~6**
—	—	2	**October 2025~~5~~6** **For Use Effective October 1, 2025~~5~~6**

Track Changes
from TOC v1.20.1
to TOC v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
TOC	—	i	3.3 Coding Conventions .....3-~~3~~4

Track Changes
from Chapter 1 v1.20.1
to Chapter 1 v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
1	1.6	1-10	**1.6 Components of the MDS** The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and residents in a Medicare Part A SNF PPS stay in non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also ~~establish~~require additional MDS ~~requirements~~assessments beyond the mandated assessment schedule. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).

Track Changes
from Chapter 2 v1.20.1
to Chapter 2 v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
2	2.3	2-6	• **Resident Transfers During a Public Health Emergency:** — When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) ~~with an **anticipated return** to the facility~~, the evacuating facility should contact their CMS Location (formerly known as Regional Office), State Agency, and Medicare Administrative Contractor (MAC) for guidance. — ~~When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their CMS Location, State Agency, and MAC for guidance.~~ — When the President declares a disaster or emergency and the Secretary of Health and Human Services declares a public health emergency and invokes the § 1135 waiver and modification authority, CMS will take steps during each declared public health emergency to identify the specific requirements that will be waived or modified under the § 1135 authority and to whom and under what circumstances such waivers or modifications will apply. — More information on § 1135 waivers can be found at: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/1135-waivers. — More information on emergency preparedness can be found at: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness.

Track Changes
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Chapter	Section	Page(s) in version 1.20.11	Change
2	2.10	2-49	Some states require providers to complete additional state-specific items (Section S) for selected assessments. Providers must ensure ~~that~~ they follow their state requirements ~~in addition to any OBRA and/or PPS requirements~~for state-specific items in Section S. States may also add ~~comprehensive~~ items from the Federal comprehensive assessment to the Quarterly and/or PPS item sets. Since these are still Federal items, state requirements do not replace, modify, or add to the item definitions, coding instructions, coding tips, or response options specified in this manual.
2	2.12	2-53	***Resident Takes a Leave of Absence from the SNF*** If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-1~~3~~4 in this chapter, there may be payment implications. For example, if a resident leaves a SNF at 6:00 p.m. on Wednesday, which is Day 27 of the resident's stay and returns to the SNF on Thursday at 9:00 a.m., then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay.

Track Changes
from Chapter 3 Intro v1.20.1
to Chapter 3 Intro v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	—	3-1	MDS 3.0 (non–Section S) items must be coded according to the CMS item definitions, coding instructions, coding tips, and response options in this manual. State or other payer requirements do not replace, modify, or add to the item definitions, coding instructions, coding tips, or response options specified in this manual.

Track Changes
from Chapter 3 Section A v1.20.1
to Chapter 3 Section A v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	A1005	A-16–A-17	Interview icon removed. A1005: Ethnicity
3	A1005	A-16	**Steps for Assessment~~: Interview Instructions~~** **For a New Admission** 1. Ask the resident to select the category or categories that most closely correspond to their ethnicity from the list in A1005, Ethnicity.
3	A1005	A-16	**For Subsequent Assessments** 1. If it has been less than a year since the resident was asked about their ethnicity, this item may be coded using the prior response to this item.
3	A1005	A-17	2. If it has been a year or more since the resident was asked about their ethnicity, initiate For a New Admission Step 1 and ask the resident about their ethnicity.
3	A1010	A-18–A-21	Interview icon removed. A1010: Race
3	A1010	A-19	**Steps for Assessment~~: Interview Instructions~~** **For a New Admission** 1. Ask the resident to select the category or categories that most closely correspond to the resident's race from the list in A1010, Race.

Track Changes
from Chapter 3 Section A v1.20.1
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Chapter	Section	Page(s) in version 1.20.11	Change
3	A1010	A-19	**For Subsequent Assessments** 1. If it has been less than a year since the resident was asked about their race, this item may be coded using the prior response to this item. 2. If it has been a year or more since the resident was asked about their race, initiate For a New Admission Step 1 and ask the resident about their race.
3	A1110	A-22–A-23	Interview icon removed. A1110: Language
3	A1255	A-25–A-27	Interview icon removed. A1255: Transportation

Track Changes
from Chapter 3 Section A v1.20.1
to Chapter 3 Section A v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	A2400	A-60	3. Resident R. began receiving services under Medicare Part A on October 15, 2021. Due to complications from their recent surgery, they were unexpectedly discharged to the hospital for emergency surgery on October 20, 2021, but are expected to return within 30 days. Code the following on their OBRA Discharge assessment: A0310F = 11 A0310G = 2 A0310H = 1 A2000 = 10-20-2021 A2105 = ~~03~~04 A2300 = 10-20-2021 A2400A = 1 A2400B = 10-15-2021 A2400C = 10-20-2021 **Rationale:** Resident R's physical discharge to the hospital was unplanned, yet it is anticipated that they will return to the facility within 30 days. Therefore, only an OBRA Discharge was required. Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.

Track Changes
from Chapter 3 Section A v1.20.1
to Chapter 3 Section A v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	A2400	A-61	5. Resident W began receiving services under Medicare Part A on November 15, 2021. Their Medicare Part A stay ended on November 25, 2021, and they were unexpectedly discharged to the hospital on November 26, 2021. However, they are expected to return to the facility within 30 days. Code the following on their OBRA Discharge assessment: A0310F = 11 A0310G = 2 A0310H = 1 A2000 = 11-26-2021 A2105 = ~~03~~04 A2300 = 11-26-2021 A2400A = 1 A2400B = 11-15-2021 A2400C = 11-25-2021 **Rationale:** Resident W's Medicare stay ended the day before discharge and they are expected to return to the facility within 30 days. Because their discharge to the hospital was unplanned, only an OBRA Discharge assessment was required. Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.

Track Changes
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Chapter	Section	Page(s) in version 1.20.11	Change
3	C0100	C-2	• If the resident interview was not conducted within the look-back period ~~(preferably the day before or the day of) the ARD~~, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "–") entered in the resident interview items.
3	C0200–C0500	C-6	• If multiple BIMS are conducted during the look-back period, code the MDS with the BIMS conducted closest to the ARD.

Track Changes
from Chapter 3 Section D v1.20.1
to Chapter 3 Section D v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	—	D-7–D-12	Page length changed due to revised content.
3	D0150	D-7	• If multiple resident mood interviews (PHQ-2 to 9©) are conducted during the look-back period, code the MDS with the resident mood interview (PHQ-2 to 9©) conducted closest to the ARD.

Track Changes
from Chapter 3 Section I v1.20.1
to Chapter 3 Section I v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	I0100–I8000: Active Diagnoses in the Last 7 Days	I-9	• Item I2300, UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to pages I-13~~4~~–I-15 for specific coding instructions for item I2300, UTI.
3	I0100–I8000: Active Diagnoses in the Last 7 Days	I-9	**Coding Instructions** *Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except item I2300, UTI, which does not use the active diagnosis 7-day look-back. Please refer to item I2300, UTI, pages I-14–I-15 for specific coding instructions).*
3	I0100–I8000: Active Diagnoses in the Last 7 Days	I-9–I-13	Aligned item names with item sets.

Track Changes
from Chapter 3 Section J v1.20.1
to Chapter 3 Section J v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	J0100	J-2	**Coding Instructions for J0100A, ~~Been on a Scheduled Pain Medication Regimen~~ Received scheduled pain medication regimen?** • **Code 0, No:** if the medical record does not contain documentation that a scheduled pain medication was received. • **Code 1, Yes:** if the medical record contains documentation that a scheduled pain medication was received.
3	J0100	J-3	**Coding Instructions for J0100B, Received PRN pain medications OR was offered and declined?** • **Code 0, No:** if the medical record does not contain documentation that a PRN medication was received or offered. • **Code 1, Yes:** if the medical record contains documentation that a PRN medication was either received OR was offered but declined. **Coding Instructions for J0100C, Received non-medication intervention for pain?** • **Code 0, No:** if the medical record does not contain documentation that a non- medication pain intervention was received. • **Code 1, Yes:** if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy.

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Chapter	Section	Page(s) in version 1.20.11	Change
3	J1100	J-25	4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities. 5. If the resident reports avoiding an activity (e.g., lying flat) due to shortness of breath, do not require the resident to perform the activity.
3	J1800	J-35	**Steps for Assessment** 1. If this is the first assessment~~/~~ since entry/admission ~~or reentry~~ (A0310E = 1 and A1700 = 1), review the medical record for the time period from the admission date to the ARD. 2. If this is ~~not~~ the first assessment~~/entry or~~ since reentry (A0310E = ~~0~~1 and A1700 = 2), ~~the~~ review ~~period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment~~the medical record for the time period from the reentry date (A1600) to the ARD. 3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.

Track Changes
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Chapter	Section	Page(s) in version 1.20.11	Change
3	M0210	M-6	• If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed. • Application of an advanced wound care dressing or skin substitute to a pressure ulcer is not a surgical procedure nor a graft or flap. • Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.
3	M0300	M-9	9. If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not "present on admission."** ~~10. If a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury **is coded as "present on admission."**~~ 10. If a resident has a pressure ulcer/injury that was documented on admission, subsequently closed (i.e., healed), and then opens again, the ulcer/injury **should not be coded as "present on admission."** 11. If two pressure ulcers merge, that were both "present on admission," continue to code the merged pressure ulcer as "present on admission." Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not "present on admission."

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Chapter	Section	Page(s) in version 1.20.11	Change
3	M0300	M-11	**Steps for Assessment** 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. 3. Reliance on only one descriptor is inadequate to determine the staging of a pressure injury between Stage 1 and deep tissue injury (see definition of "deep tissue injury" on page M-247). The descriptors are similar for these two types of injuries (e.g., temperature [warmth or coolness]; tissue consistency [firm or boggy]).

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Chapter	Section	Page(s) in version 1.20.11	Change
3	M0300	M-17	3. On admission, the resident has three small Stage 2 pressure ulcers on their coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer. **Coding:** The admission coding would be **M0300B1 as 3, and M0300B2 as ~~1~~3, present on admission/entry or reentry**. On the subsequent assessment, the two merged pressure ulcers would be coded at **M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry**. The Stage 3 pressure ulcer would be **coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry**. **Rationale:** On the subsequent assessment, two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; therefore, **M0300B1 and M0300B2 would be coded as 1**; the pressure ulcer that increased in numerical stage to a **Stage 3 is coded in M0300C1 as 1 and in M0300C2 as 0**, not present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry and developed a deeper level of tissue damage in the time since admission.

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Chapter	Section	Page(s) in version 1.20.11	Change
3	M0300	M-22	**Steps for Assessment** 1. Review the medical record for documentation of a pressure ulcer/injury covered by a non- removable dressing/device. 2. Determine the number of documented pressure ulcers/injuries covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing or an orthopedic device that is not to be removed per physician's order, or a cast. 3. Identify the number of these pressure ulcers/injuries that were present on admission/entry or reentry (see page M-~~7~~8 for assessment process).
3	M0300	M-23	**Steps for Assessment** 1. Determine the number of pressure ulcers that are unstageable due to slough and/or eschar. 2. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-~~7~~8 for assessment process).
3	M0300	M-28	5. Determine the number of pressure injuries that are unstageable related to deep tissue injury. 6. Identify the number of **these** pressure injuries that were present on admission/entry or reentry (see page M-~~7~~8 for instructions). 7. Clearly document assessment findings in the resident's medical record, and track and document appropriate wound care planning and management.
3	M1040	M-33	• **M1040C,** Other open lesion(s) on the foot ~~(e.g., cuts, fissures)~~ • **M1040D,** Open lesion(s) other than ulcers, rashes, cuts (e.g., ~~bullous pemphigoid~~cancer lesion) • **M1040E,** Surgical wound(s)

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Chapter	Section	Page(s) in version 1.20.11	Change
3	M1040	M-34	**M1040C, Other open lesion(s) on the foot** • This item is designed to capture open lesions that are located on the foot and not otherwise captured in M1040A, Infection of the foot (e.g., cellulitis, purulent drainage), or M1040B, Diabetic foot ulcer(s). • Examples of open lesions on the foot include but are not limited to cuts or fissures. • Do not code open lesions that are otherwise captured in other Section M items. **M1040D, Open lesion(s) other than ulcers, rashes, cuts** • Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, bullous pemphigoid lesions, boils, cysts, and vesicles, should be coded in this item.
3	M1040	M-35	• Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound. • If an advanced wound care dressing or skin substitute is applied to the pressure ulcer, it is not coded as a surgical wound because its application does not require a surgical procedure.
3	M1200	M-38	• **M1200F,** Surgical wound care • **M1200G,** Application of non-surgical dressings (with or without topical medications) other than to feet~~. Non-surgical dressings do not include Band-Aids.~~ • **M1200H,** Application of ointments/medications other than to feet

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Chapter	Section	Page(s) in version 1.20.11	Change
3	M1200	M-40	**M1200E, Pressure ulcer/injury care** • Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (M0300A–G). Examples may include the use of topical dressings; enzymatic, mechanical or surgical debridement; wound irrigations; negative pressure wound therapy (NPWT); and/or hydrotherapy. • Topical dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).

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Chapter	Section	Page(s) in version 1.20.11	Change
3	M1200	M-40	**M1200F, Surgical wound care** • Does not include post-operative care following eye or oral surgery. • Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure ulcer/injury care**. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer. • Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application. • Dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips). • Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound. • Application of an advanced wound care dressing or skin substitute to a pressure ulcer is not coded as surgical wound care because the resident did not have a surgical procedure, and thus, any wound care associated with advanced wound care dressings or skin substitutes to a pressure ulcer would be coded in **M1200E, Pressure ulcer/injury care**.

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Chapter	Section	Page(s) in version 1.20.11	Change
3	M1200	M-41	**M1200I, Application of dressings to the feet (with or without topical medications)** • Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer/injury**. • Do **not** code application of dressings to pressure ulcers/injuries on the foot; use M1200E, Pressure ulcer/injury care. • Do not code application of dressings to the ankle. The ankle is not considered part of the foot. • Dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).

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Chapter	Section	Page(s) in version 1.20.11	Change
3	O0110	O-8	• **O0110M1, Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)** Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of an active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a highly transmissible or epidemiologically significant pathogens ~~that have been acquired by physical contact or airborne or droplet transmission~~. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections. Code for "single room isolation" only when all of the following conditions are met: 1. The resident has an active infection with a highly transmissible or epidemiologically significant pathogens ~~that have been acquired by physical contact or airborne or droplet transmission~~. 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. The resident must remain in their room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

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Chapter	Section	Page(s) in version 1.20.11	Change
3	O0390	O-23	• Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall count towards the 15 minutes per day on one or more days when coding the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers or receives a nebulizer treatment or maintenance level/prophylactic incentive spirometry without clinically indicated or medically necessary supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

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Chapter	Section	Page(s) in version 1.20.11	Change
3	O0390	O-25	**Non-Skilled Services** • Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall **not** be counted in items O0390, Therapy Services; O0400, Therapies; or O0425, Part A Therapies, even when performed by a therapist or an assistant. • As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. In these situations, the services shall **not** be coded as therapy in items O0390, Therapy Services; O0400, Therapies; or O0425, Part A Therapies, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in items O0390, Therapy Services; O0400, Therapies; or O0425, Part A Therapies. These services should be documented in the resident's medical record.

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Chapter	Section	Page(s) in version 1.20.11	Change
3	O0390	O-32	**Therapy Modalities** Only skilled therapy time (i.e., time that requires the skills, knowledge, and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot pack or maintenance level/prophylactic incentive spirometry is often not a skilled intervention. However, when the resident's condition is complicated and/or the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS. The use and rationale for all therapy modalities, whether skilled or unskilled, should always be documented as part of the individual resident~~'s~~-specific plan of care.

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Chapter	Section	Page(s) in version 1.20.11	Change
3	O0390	O-33	3. During the observation period, Resident S received 10 minutes of skilled respiratory therapy on day one, 7 minutes of skilled respiratory therapy on day four and 13 minutes of skilled respiratory therapy on day five of the observation period. **Coding:** O0390D would **not be checked**. **Rationale:** Resident S did not receive at least 15 minutes of skilled respiratory therapy on a single day during the observation period. 4. During the observation period, Resident P, who has stable COPD and no symptoms of respiratory distress, had an order for daily incentive spirometry to prevent respiratory decline. Nursing staff assisted Resident P to use the incentive spirometer and documented that Resident P completed the incentive spirometry for 15 minutes on each day of the observation period. **Coding:** O0390D would **not be checked**. **Rationale:** While nursing staff assisted the resident with their routine incentive spirometry use, given the resident's stable condition and absence of respiratory distress, the maintenance level/prophylactic treatment did not require the skills, knowledge, and judgment of a respiratory therapist or respiratory nurse and therefore did not meet the criteria for skilled respiratory therapy.

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Chapter	Section	Page(s) in version 1.20.11	Change
3	O0400	O-34	**Steps for Assessment** 1. Complete only if O0390D, Respiratory Therapy, is checked. 2. Review the resident's medical record ~~(e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes),~~ and consult with each of the qualified care providers to collect the information required for this item. 3. Apply the therapy coding guidance from O0390, Therapy Services, for coding O0400D, Respiratory Therapy. **Coding Instructions** • **Days**—Enter the number of days skilled respiratory therapy services were provided in the last 7 days. A day of therapy is defined as skilled treatment for 15 minutes or more ~~in~~during the day. ~~**Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes during the last 7 days is 0, skip this item and leave blank.~~

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to Chapter 3 Section O v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	O0400	O-34	**Example** 1. Following a stroke and aspiration pneumonia, Resident F was admitted to the skilled nursing facility ~~in stable condition for rehabilitation therapy~~ on 10/06/~~19~~26 under Medicare Part A skilled nursing facility coverage. ~~Their diagnoses included asthma, and t~~They were referred to respiratory therapy. During the 7-day look-back period, the resident received skilled respiratory therapy services Sunday–Wednesday for 10 minutes each day and Thursday–Saturday for 15 minutes each day. ~~Respiratory therapy services that were provided over the 7-day look-back period:~~ • ~~Respiratory therapy services; Sunday–Thursday for 10 minutes each day.~~ **Coding:** O0400D2 would be **coded ~~03~~3**. **Rationale:** ~~Total minutes were 50 over the 7-day look-back period (10 × 5 = 50). Although a total of 50 minutes of respiratory therapy services were provided over the 7-day look-back period, there were not any days that respiratory therapy was provided for 15 minutes or more.~~The resident only received skilled respiratory therapy services for 15 minutes on 3 days. Therefore, O0400D equals **~~zero~~3 days**.
3	O0425	O-36	• Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) ~~and respiratory, psychological, and recreational therapy~~ can help residents to attain or maintain their highest level of well-being and improve their quality of life.
3	O0425	O-37	**Steps for Assessment** 1. Complete only if A0310H (Is this a SNF Part A PPS Discharge Assessment?) = 1, Yes. 2. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records~~, recreation therapy notes, mental health professional progress notes~~), and consult with each of the qualified care providers to collect the information required for this item.

Chapter	Section	Page(s) in version 1.20.11	Change
3	O0425	O-40	**General Coding Example:** Following a bilateral knee replacement, Resident G was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on Sunday 10/06/19 under Part A skilled nursing facility coverage. While in the hospital, they exhibited some short-term memory difficulties specifically affecting orientation. They were non-weight bearing, had reduced range of motion, and had difficulty with ADLs. They were referred to SLP, OT, and PT with the long-term goal of returning home with their spouse. Their initial SLP evaluation was performed on 10/06/19, and the OT and PT initial evaluations were done on 10/07/19. ~~They were also referred to recreational therapy.~~ They were in the SNF for 14 days and were discharged home on 10/19/2019. Resident G received the following rehabilitation services during their stay in the SNF.

Track Changes
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Chapter	Section	Page(s) in version 1.20.11	Change
3	P0100	P-5	• When coding this section, do not consider as a restraint a locked/secured unit or building in which the resident has the freedom to move about the locked/secured unit or building. Additional guidance regarding locked/secured units is provided ~~in the section "~~under 42 CFR § 483.12(a)(1), Considerations Involving Secured/Locked Areas~~" of F603~~, in Appendix PP of the State Operations Manual.
3	P0200	P-11	• When determining whether the use of an alarm also meets the criteria of a restraint, refer to ~~the section "~~42 CFR § 483.12(a)(1), Determination of the Use of Position Change Alarms as Restraints~~" of F604~~, in Appendix PP of the State Operations Manual ~~available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf~~.

Track Changes
from Chapter 3 Section Z v1.20.1
to Chapter 3 Section Z v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
3	Z0200	Z-2	~~**Coding Instructions for Z0200C, Is this a Short Stay assessment?**~~ • ~~**Code 0, no:** if this is not a Short Stay assessment.~~ • ~~**Code 1, yes:** if this is a Medicare Short Stay assessment.~~ ~~**Coding Tip**~~ • ~~The standard RUG-IV grouper automatically determines whether or not this is a Short Stay assessment. MDS software typically makes this determination automatically.~~

Track Changes
from Chapter 4 v1.20.1
to Chapter 4 v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
4	4.7	4-8	**4.7 The RAI and Care Planning** As required at 42 CFR § 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Refer to 42 CFR § 483.20(d), which notes that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. Regulatory requirements related to care planning in nursing homes are located at 42 CFR § 483.2~~0(b)(1) and (2)~~1 and are specified in the interpretive guidelines (F tags) in Appendix PP of the State Operations Manual (SOM). The SOM can be found at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms1201984.

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Chapter	Section	Page(s) in version 1.20.11	Change
6	6.4	6-6–6-8	**Table 3. Third Character: Nursing Component** [redacted] | Clinical Conditions | Depression Signs and Symptoms | # of Restorative Nursing Services | [redacted] [redacted] | - | - | - | [redacted] [redacted] | - | - | - | [redacted] Note: Black bars represent hidden columns to condense table.

Track Changes
from Chapter 6 v1.20.1
to Chapter 6 v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
6	Category: Special Care High	6-36	**STEP #1** Determine whether the resident is coded for **one** of the following conditions or services: B0100, Section GG items — Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88) I2100 — Septicemia I2900, N0350A, B — Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B) I5100, Nursing Function Score — Quadriplegia with Nursing Function Score <= 11 I6200, J1100C — Asthma, ~~C~~chronic obstructive pulmonary disease, or chronic lung disease **and** shortness of breath when lying flat J1550A, others — Fever and one of the following: I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0520B2 or K0520B3 Feeding tube*

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Chapter	Section	Page(s) in version 1.20.11	Change
6	Category: Special Care High	6-37	**STEP #3** Evaluate for signs and symptoms of depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation, in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:
6	Category: Special Care High	6-37	These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. The resident qualifies ~~as depressed~~for depression signs and symptoms for PDPM classification in either of the two following cases: The D0160, Total Severity Score, is greater than or equal to 10 but not 99, **or** The D0600, Total Severity Score, is greater than or equal to 10. **Resident Qualifies ~~as Depressed~~for Depression Signs and Symptoms** **Yes _____ No _____**

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<table>
<tr><th>Chapter</th><th>Section</th><th>Page(s) in version 1.20.11</th><th>Change</th></tr>
<tr><td>6</td><td>Category: Special Care High</td><td>6-38</td><td>
STEP #4

Select the Special Care High classification based on the PDPM Nursing Function Score and the presence or absence of depression signs and symptoms according to this table:
<table>
<tr><th>Nursing Function Score</th><th><s>Depressed</s> Depression Signs and Symptoms?</th><th>PDPM Nursing Classification</th></tr>
<tr><td>0–5</td><td>Yes</td><td>HDE2</td></tr>
<tr><td>0–5</td><td>No</td><td>HDE1</td></tr>
<tr><td>6–14</td><td>Yes</td><td>HBC2</td></tr>
<tr><td>6–14</td><td>No</td><td>HBC1</td></tr>
</table>
PDPM Nursing Classification: _____
</td></tr>
<tr><td>6</td><td>Category: Special Care Low</td><td>6-40</td><td>
STEP #3

Evaluate for signs and symptoms of depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation, in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:
</td></tr>
</table>

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<table>
<tr><th>Chapter</th><th>Section</th><th>Page(s) in version 1.20.11</th><th>Change</th></tr>
<tr><td>6</td><td>Category: Special Care Low</td><td>6-41</td><td>
These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. The resident qualifies ~~as depressed~~for depression signs and symptoms for PDPM classification in either of the two following cases:

The D0160, Total Severity Score, is greater than or equal to 10 but not 99,

or

The D0600, Total Severity Score, is greater than or equal to 10.

Resident Qualifies ~~as Depressed~~for Depression Signs and Symptoms

Yes _____ No _____

STEP #4

Select the Special Care Low classification based on the PDPM Nursing Function Score and the presence or absence of depression signs and symptoms according to this table:
<table>
<tr><th>Nursing Function Score</th><th>~~Depressed~~ Depression Signs and Symptoms?</th><th>PDPM Nursing Classification</th></tr>
<tr><td>0–5</td><td>Yes</td><td>LDE2</td></tr>
<tr><td>0–5</td><td>No</td><td>LDE1</td></tr>
<tr><td>6–14</td><td>Yes</td><td>LBC2</td></tr>
<tr><td>6–14</td><td>No</td><td>LBC1</td></tr>
</table>
PDPM Nursing Classification: _____
</td></tr>
</table>

Track Changes
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Chapter	Section	Page(s) in version 1.20.11	Change
6	Category: Clinically Complex	6-42	**STEP #2** Evaluate for signs and symptoms of depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation, in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

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<table>
<tr><th>Chapter</th><th>Section</th><th>Page(s) in version 1.20.11</th><th>Change</th></tr>
<tr><td>6</td><td>Category: Clinically Complex</td><td>6-43</td><td>
The resident qualifies ~~as depressed~~for depression signs and symptoms for PDPM classification in either of the two following cases:

The D0160, Total Severity Score, is greater than or equal to 10 but not 99,

or

The D0600, Total Severity Score, is greater than or equal to 10.

Resident Qualifies ~~as Depressed~~for Depression Signs and Symptoms

Yes _____ No _____

STEP #3

Select the Clinically Complex classification based on the PDPM Nursing Function Score and the presence or absence of depression signs and symptoms according to this table:
<table>
<tr><th>Nursing Function Score</th><th>~~Depressed~~ Depression Signs and Symptoms?</th><th>PDPM Nursing Classification</th></tr>
<tr><td>0–5</td><td>Yes</td><td>CDE2</td></tr>
<tr><td>0–5</td><td>No</td><td>CDE1</td></tr>
<tr><td>6–14</td><td>Yes</td><td>CBC2</td></tr>
<tr><td>15–16</td><td>Yes</td><td>CA2</td></tr>
<tr><td>6–14</td><td>No</td><td>CBC1</td></tr>
<tr><td>15–16</td><td>No</td><td>CA1</td></tr>
</table>
PDPM Nursing Classification: _____
</td></tr>
</table>

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to Chapter 6 v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
6	Category: Behavioral Symptoms and Cognitive Performance	6-46	**STEP #5** **Determine Restorative Nursing Count** Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days: H0200C, H0500**±/** — Urinary toileting program and/or bowel toileting program O0500A, B*± — Passive and/or active range of motion O0500C — Splint or brace assistance O0500D, F*± — Bed mobility and/or walking training O0500E — Transfer training O0500G — Dressing and/or grooming training O0500H — Eating and/or swallowing training O0500I — Amputation/prostheses care O0500J — Communication training **±Count as one service even if both provided **Toileting programs (H0200C and H0500) do not require day/minute documentation **Restorative Nursing Count: _____**

Track Changes
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to Chapter 6 v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
6	Category: Reduced Physical Function	6-47	**STEP #2** **Determine Restorative Nursing Count** Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days: H0200C, H0500**±/** — Urinary toileting program and/or bowel toileting program O0500A, B*± — Passive and/or active range of motion O0500C — Splint or brace assistance O0500D, F*± — Bed mobility and/or walking training O0500E — Transfer training O0500G — Dressing and/or grooming training O0500H — Eating and/or swallowing training O0500I — Amputation/prostheses care O0500J — Communication training *±Count as one service even if both provided **Toileting programs (H0200C and H0500) do not require day/minute documentation **Restorative Nursing Count: _____**

Track Changes
from Appendix C v1.20.1
to Appendix C v1.20.11

Chapter	Section	Page(s) in version 1.20.11	Change
Appendix C	Care Area General Resources	Appendix C-85	• Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: https://www.ahrq.gov/prevention/clinician/index.html; • Academy of Nutrition and Dietetics – Individualized Nutrition Approaches for Older Adults ~~in Health Care Communities~~: Long-Term Care, Post-Acute Care, and Other Settings (PDF Version): ~~https://dhcc.eatrightpro.org/resources/clinical-resources~~ https://www.eatrightpro.org/practice/guidelines-and-positions/academy-positions; • Alzheimer's Association Resources: https://www.alz.org/;