Ready or Not: Preparing for the Oct. 1, 2025, MDS Changes

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Learner Objectives:

After participating in this session, learners will be able to:

- Identify key changes to the MDS 3.0 assessment and RAI User's Manual effective Oct. 1, 2025
- Explain how the updated items influence clinical documentation and interdisciplinary collaboration
- Recognize best practices and tools to ensure accurate coding and regulatory compliance under the new MDS guidelines

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Section A

- A0810
  - Terminology update from “gender” to “sex”
  - Also updated in section X

A0810. Sex	
Enter Code ☐	1. Male 2. Female

Also changed in section X, X0310: Sex

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Section A

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

Key Takeaway:
Does not apply to resident residing in the facility for more than a year.

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Section A

- Updated instructions for A1255, Transportation
- Steps for Assessment
  1. Ask the resident, "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?"
  2. Ask the resident to select the response that most closely corresponds to the resident's transportation status from the list in A1255
  3. If the resident declines to respond, code 7, Resident declines to respond, and do not code based on other resources (family, significant other, or legally authorized representative or medical records)
  4. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative
  5. Only use medical record documentation to code A1255, Transportation if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item

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Section A

Updated instructions for A1255, Transportation

- Coding Instructions
  - Code 0, Yes: if the resident indicates that in the past 12 months, a lack of reliable transportation kept them from medical appointments, meetings, work or from getting things needed for daily living
  - Code 1, No: if the resident indicates that in the past 12 months, a lack of reliable transportation has not kept them from medical appointments, meetings, work, or from getting things needed for daily living
  - Code 7, Resident declines to respond: if the resident declines to respond.
    - — When the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records)
  - Code 8, Resident unable to respond: if the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information

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Section A

- New coding tips for A1255, Transportation
- Coding Tips
  - A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence
  - If the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical records, select the response that applies
  - This item is only collected for residents whose episode of care is less than 366 days (i.e., A2300 minus A1900 is less than 366 days)

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Section A

- New example for A1255, Transportation

2. Resident B indicates that in the last 12 months, they have not had reliable transportation, which has occasionally kept them from attending medical appointments.

Coding: A1255, Transportation would be coded as 0, Yes.

Rationale: Resident B reported they have not had access to reliable transportation in the last 12 months, which has kept them from medical appointments, meetings, work or from getting things needed for daily living.

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Section D

New coding tip for PHQ-2 to 9:

- In the rare situation that the resident cannot provide a frequency, following a yes response to a symptom in Column 1, enter a dash in Column 2

- Added "or dashed" in tip
  - If symptom frequency in items D0150A2 through D0150I2 is blank or dashed for 3 or more items, the interview is deemed NOT complete

Key Takeaway:
Dash could have substantial impact on mood interview; use cue cards to assist the resident with determining frequency.

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Section GG

- Removed several examples for prior functioning
  - Did not change intent of coding

Additional Consideration:
No coding tip or guidance should be applied in isolation; must consider all instructions for the section.

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Section GG

- Prior Functioning
  - New coding tip
    - For the GG0100C stair activity, “by any safe means” may include a resident scooting up and down stairs on their buttocks
- Prior Device Use
  - New coding tip
    - Clinical judgment may be used to determine whether other devices meet the definition provided

Key Takeaway:
Clinical judgement is a key part of section GG coding.

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Section GG

- Clarified “helper” definition applies only to GG0130 and GG0170
  - For the purposes of completing **items GG0130 and GG0170**, a “helper” is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, “helper” does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration such as hospice staff, nursing/certified nursing assistant students, etc…

Key Takeaway:
This definition for “helper” does not apply to prior functioning at GG0100.

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Section GG

- New general coding tip
  - Assessment of the 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 (e.g., walking might be assessed for a resident who did/does/will use a wheelchair as their primary mode of mobility, stair activities might be assessed for a resident not routinely accessing stairs)

Key Takeaway:
To assess usual performance for a task, the task does not need to be routinely preformed.

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Section GG

- New general coding tips:
  - The assessment timeframe is up to 3 calendar days based on the target date. During the assessment timeframe, some activities may be performed by the resident multiple times, whereas other activities may only occur once
  - A dash (-) indicates "No information." CMS expects dash use to be a rare occurrence

Key Takeaway:
Even if the activity only occurs once during the 3-day assessment period, the determination of usual performance should be based on that performance.

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Section GG

- New general coding tips:
  - CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Clinical assessments 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)

Key Takeaway:
The resident's performance should be assessed with the assistive devices the resident needs to safely complete the task; this does not include devices restricted to therapy sessions.

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Section GG

- Usual performance
  - New coding tip:
    - If two or more helpers are required to assist the resident in completing the activity, code as 01, Dependent

Key Takeaway:
Documenting the number of helpers needed is required for accurate coding.

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Section GG

- Eating
  - New coding tip:
    - The adequacy of the resident's nutrition or hydration is not considered for GG0130A, Eating

Key Takeaway:
The eating tasks must focus on the resident's ability to eat, not the quality or nutritional value of the food.

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Section GG

- Dressing items:
  - New coding tips:
    - Consider an item that covers all or part of the foot as footwear, even if it extends up the leg, and do not also consider it as a lower-body dressing item
    - If the resident wears just shoes or just socks (e.g., grip socks) that are safe for mobility, then GG0130H, Putting on/taking off footwear, may be coded

Key Takeaway:
Footwear, such as compression stockings, that extend past the ankle are only considered footwear and not also coded as lower body dressing.

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Section GG

- Bed mobility items
  - New coding tip:
    - For GG0170A, Roll left and right; GG0170B, Sit to lying; and GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for the resident. For example, a clinician could determine that a resident's preferred slightly elevated resting position is "lying" for a resident

Key Takeaway:
Clinical judgement for what is "lying" applies to all bed mobility items.

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Section GG

- Walking items
  - New coding tips:
    - Do not code walking activities with the use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems)
    - If the resident who participates in walking 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 resident use, then enter code 05, Setup or clean-up assistance

Key Takeaway:
Walking items can be coded as dependent if two helpers are required to safely complete the task.

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Section GG

- Stairs/step items
  - New coding tips:
    - 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

Key Takeaway:
Stairs/Step items start once the resident is standing at the stairs or step.

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Section J

Updated definition for Fall

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.

Key Takeaway:
Now includes "overwhelming external force" as a cause for a fall.

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Section J

Updated definition for Fall

- **Removed** from fall definition:
  - "The fall 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. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident)"

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Section J

Removed from fall definition:

- CMS understands that challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls

Updated Coding tip:

- CMS understands that challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls. 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

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Section J

Updated definition of injury except major:

- **Injury (except major)**
  - Includes, *but is not limited to,* skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain

Key Takeaways:
Injuries listed is not an all-inclusive list.

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Section J

Updated definition of major injury:

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

Removed:

- Closed head injuries with altered consciousness, subdural hematoma

Key Takeaways:
Extends the inclusions of major injury.
Clarifies bone fractures are traumatic (not pathological).
Now includes all head injuries.

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Common Definitions

- **Subluxation** – A partial dislocation of a joint, where a bone slips partly out of its normal position but still maintains some contact with other bones
- **Internal organ injury** – Refers to injuries or damage to the organs located within the body's cavities, such as the heart, lungs, liver, kidneys, and intestines
- **Spinal cord injury –** Damage to the spinal cord, a bundle of nerves that runs from the brain to the rest of the body
- **Head injury –** Any trauma to the scalp, skull, or brain
- **Crush injury –** occurs when a body part is trapped or compressed under excessive force, resulting in damage to the underlying tissues. For a fall, this would likely be due to falling from a significant height

Note: The *RAI User's Manual* does not define these terms. These are general definition to be used for informational purpose and must not be to used for coding decisions.

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Section J

- **Added coding tip:**
  - Fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall

Key Takeaways:
Clarifies, beyond the definition, that only traumatic bone fractures are included in the major injury fall definition.

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Section J

- New example for J1800 and J1900:

6.The therapist had Resident S, who has Parkinson's disease, stand on one foot during their therapy session to intentionally challenge the resident's balance. Despite providing contact guard assistance and use of safety mats, Resident S fell and landed on their left side. An X-ray was ordered due to pain and swelling of the left wrist which confirmed a distal radius fracture of the left wrist.

Coding: J1800 would be coded 1, yes and J1900C would be coded 1, one.

Rationale: Despite safety precautions in place, Resident S sustained a radius fracture as a result of a fall during a therapeutic intervention with physical therapy. This is a fall, as the clinician's interventions did not intercept the loss of balance, and the resident landed on the floor and sustained a fracture, which is a major injury.

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Section J

- Two new examples for traumatic vs pathological fractures:

7. 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.

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Section J

- Two new examples for traumatic vs pathological fractures:

8. 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.

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Section K

- Added instruction for K0300 (Weight loss) and K0310 (Weight gain):
  - The resident's weight captured closest to these two time points are the only two weights considered for this item, but the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary
- Added tip for K0300 (Weight loss) and K0310 (Weight gain):
  - In cases in which multiple weights for the resident may exist during the time period being evaluated, select the weight on the date closest to the appropriate time point

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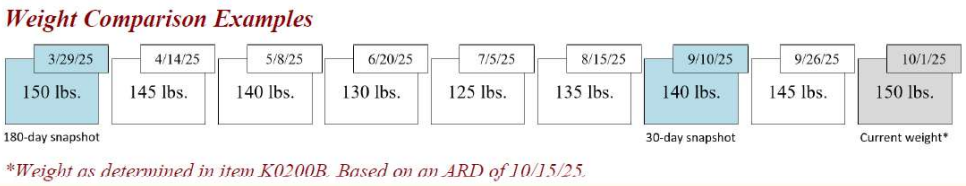
Section K

- Added illustrates for K0300 (Weight loss) and K0310 (Weight gain) – calculation from date of current weight used on the MDS to the weight is closest to 30 days or 180 days



Key Takeaway:
The weights could be before or after the 30-day and 180-day points.

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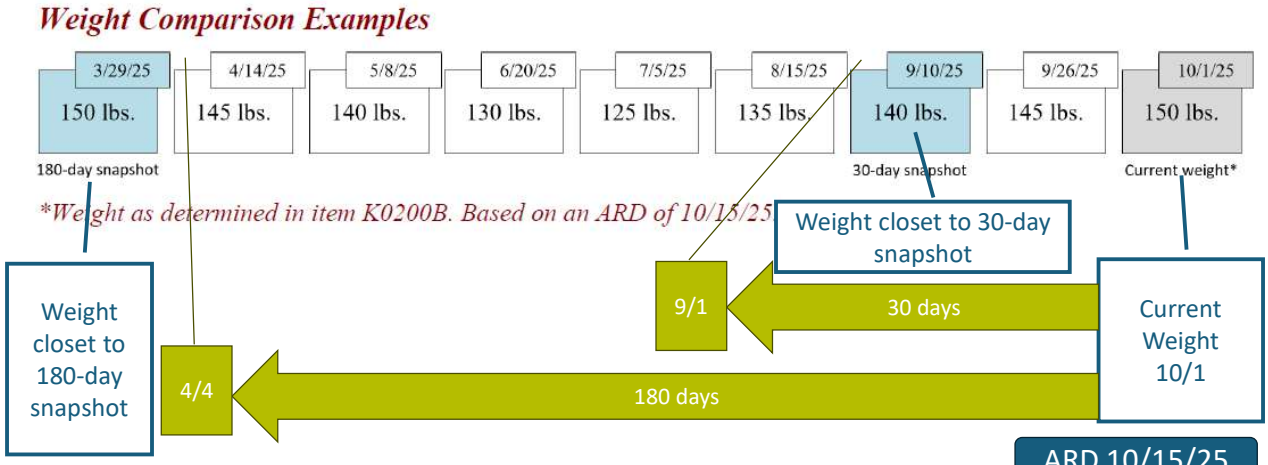
Section K



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Section M

- New step for completing M0300A-G
  - Step 3: **Determine "Present on Admission"**
    - 4. 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"
    - 12. 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. For example, if a resident is admitted with a deep tissue injury, but later the injury opens, the wound bed is covered with slough, and the wound is still unstageable, this wound would still be considered "present on admission"

Key Takeaway:
Present on admission depends on staged or unstaged at admission.

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Section N

Replaced coding tip:

- Removed:
  - In circumstances where reference materials vary in identifying a medication's therapeutic category and/or pharmacological classification, consult the resources/links cited in this section or consult the medication package insert, which is available through the facility's pharmacy or the manufacturer's website. If necessary, request input from the consulting pharmacist

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Section N

Replaced coding tip:

- New:
  - Facilities may wish to identify a resource that their staff consistently use to identify pharmacological classification as assessors should be able to identify the source(s) used to support coding the MDS 3.0
  - Assessors should consult the manufacturer's package insert, which may contain the medication's pharmacological classification. They can also work with the resident's pharmacist to confirm the medication classification(s) for a resident's medication(s)

Key Takeaway:
Identify the resource your facility will use for pharmacological classification.

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Section N

- Clarified coding tip:
  - Do not code flushes to keep IV access patent in N0415E, Anticoagulant

Key Takeaway:
IV flushes, like heparin, just to IV access patent are not coded as an anticoagulant.

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Section O

- Pneumococcal vaccines:
  - Updated links
  - Updated examples

Key Takeaway:
Must reference updated guidance from the CDC for update to date.

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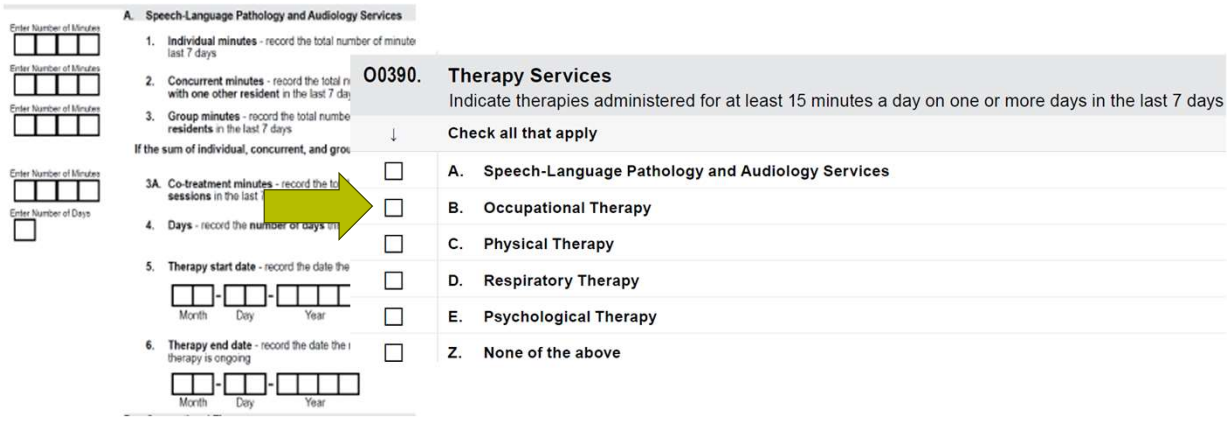
Section O

- Replaced majority of O0400 with O0390



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Section O

- Majority of text in O0390 carried over from O0400
  - Item rationale
  - Steps for Assessment
  - **New: Coding Instructions**
  - Minutes of Therapy
  - Non-Skilled Services
  - Co-Treatment
  - Therapy Aides and Students
  - Modes of Therapy
  - **CUT: Dates of Therapy**
  - **New: Examples**

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Section O

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

Key Takeaway:
Detailed volume of therapy is no longer routinely collected by CMS; detailed days and minutes only collected during a skilled Medicare stay (O0425).

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Section O

- O0400D
  - Only item retained from O0400
  - Required for PDPM nursing component
  - Only completed if O0390D is checked

O0400. Therapies Complete only if O0390D is checked	
D. Respiratory Therapy	
Enter Number of Days ☐	2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

Key Takeaway:
Minutes are not coded but still must have 15 minutes to count a day.

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Section O

O0400D: Respiratory Therapy

- Steps for assessment
  - 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
- Coding instructions:
  - **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in 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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Section O

O0400D: Respiratory Therapy

- Updated example
  - Following a stroke, Resident F was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/19 under Part A skilled nursing facility coverage. Their diagnoses included asthma, and they were referred to respiratory therapy.
  - 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 0

    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. Therefore, O0400D equals zero

Section X

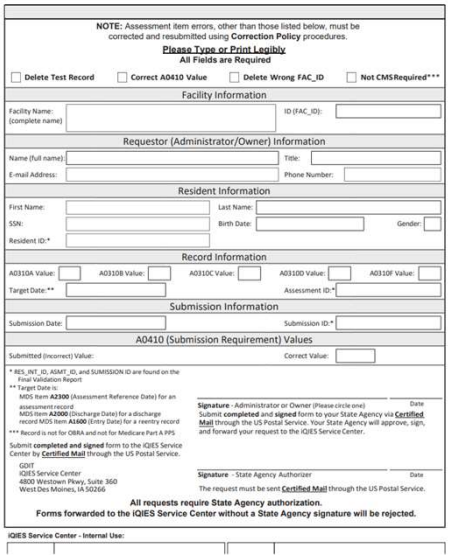
Correction Request

- Clarified difference between modification and inactiviation and a manual deletion:
  - The modification and inactivation processes do not remove the prior erroneous record from iQIES. The erroneous record is archived in a history file. In certain cases, it is necessary to delete or change a record and not retain any information about the record in iQIES. This requires the facility to complete an MDS 3.0 Individual Correction Request or MDS 3.0 Individual Deletion Request in iQIES. Additionally, in situations in which the state-assigned facility submission ID (FAC_ID) or state code (STATE_CD) is incorrect, an MDS 3.0 Manual Assessment Move Facility Request is required. The policy and procedures for these special requests are provided in Chapter 5 of this Manual.

Key Takeaway:
An inactivation or modification does not remove the record from iQIES.

Manual Deletion Form

- https://iqies.cms.gov/iqies/mds/static/assets/MDS%203.0%20Manual%20Individual%20Assessment%20Correction%20Deletion%20Request.1dcad7329802efa7b8d4.pdf



NOTE: Assessment item errors, other than those listed below, must be corrected and resubmitted using **Correction Policy** procedures.

Please Type or Print Legibly

All Fields are Required

☐ Delete Test Record ☐ Correct A0410 Value ☐ Delete Wrong FAC_ID ☐ Not CMS Required***

Facility Information

Facility Name: (complete name) | ID (FAC_ID):

Requestor (Administrator/Owner) Information

Name (full name): | Title:

E-mail Address: | Phone Number:

Resident Information

First Name: | Last Name:

SSN: | Birth Date: | Gender:

Resident ID:*

Record Information

A0310A Value: | A0310B Value: | A0310C Value: | A0310D Value: | A0310F Value:

Target Date:** | Assessment ID:*

Submission Information

Submission Date: | Submission ID:*

A0410 (Submission Requirement) Values

Submitted (Incorrect) Value: | Correct Value:

* RES_INT_ID, ASMT_ID, and SUMISSION ID are found on the Final Validation Report

** Target Date is:
MDS Item **A2300** (Assessment Reference Date) for an assessment record
MDS Item **A2000** (Discharge Date) for a discharge record MDS Item **A1600** (Entry Date) for a reentry record

*** Record is not for OBRA and not for Medicare Part A PPS

Submit **completed and signed** form to the iQIES Service Center by **Certified Mail** through the US Postal Service.

GDIT
iQIES Service Center
4800 Westown Pkwy, Suite 360
West Des Moines, IA 50266

Signature - Administrator or Owner (Please circle one) Date

Submit **completed** and **signed** form to your State Agency via **Certified Mail** through the US Postal Service. Your State Agency will approve, sign, and forward your request to the iQIES Service Center.

Signature - State Agency Authorizer Date

The request must be sent **Certified Mail** through the US Postal Service.

All requests require State Agency authorization.
Forms forwarded to the iQIES Service Center without a State Agency signature will be rejected.

iQIES Service Center - Internal Use:

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Section X

- Correction Request
- Clarified the four reasons a special request for manual deletion would be required:
  - **1. Item A0410 Submission Requirement is incorrect.** Submission of MDS assessment records to iQIES constitutes a release of private information and must conform to privacy laws. Only records required by the State and/or the Federal governments may be stored in the iQIES. If a record has been submitted with the incorrect Submission Requirement value in Item A0410, then the facility must request correction of A0410 via an MDS 3.0 Individual Deletion Request or MDS 3.0 Individual Correction Request in iQIES. Item A0410 cannot be corrected by modification or inactivation. See Chapter 5 of this Manual and the iQIES Assessment Management: Assessment Submitter Manual for details

Key Takeaway:
An error in A0410 (submission requirement) requires a manual deletion request.

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Section X

- Correction Request
- Clarified the four reasons a special request for manual deletion would be required:
  - **2. Record was submitted with the incorrect state-assigned facility submission ID (FAC_ID) or state code (STATE_CD).** If a record was submitted to iQIES for an incorrect facility or with an incorrect state code, the record must be manually corrected by the State Agency. In these situations, the facility must complete an MDS 3.0 Manual Assessment Move Facility Request and send the request via certified mail to the State Agency

Key Takeaway:
An error in facility or state code requires a manual deletion request.

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Section X

- Correction Request
- Clarified the four reasons a special request for manual deletion would be required:
  - 3. **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 deletion via an MDS 3.0 Individual Deletion Request in iQIES 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.*

Key Takeaway:
When an assessment not used Medicare or OBRA is submitted in error, such as submitting a 5-Day for a MA Plan, a manual deletion request is required.

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Section X

- Correction Request
- Clarified the four reasons a special request for manual deletion would be required:
  - 4**. Inappropriate submission of a test record as a production record.** Removal of a test record from iQIES requires record deletion via an MDS 3.0 Individual Deletion Request in iQIES. Otherwise, information for a "bogus" resident will be retained in the database and this resident will appear on some reports to the facility.

Key Takeaway:
Submission of a test record required a manual deletion request.

Chapter 5

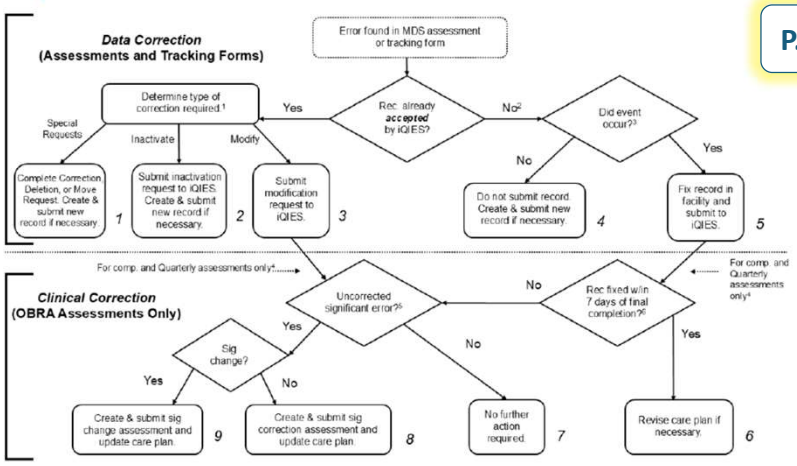
- Correcting Errors in MDS Records That Have Been Accepted Into iQIES
- Clarified difference between modification and inactivation and a manual deletion:
  - A Modification Request moves the inaccurate record into history in iQIES and replaces it with the corrected record as the active record. An Inactivation Request also moves the inaccurate record into history in iQIES but does not replace it with a new record. Both the Modification and Inactivation processes require the MDS Correction Request items to be completed in Section X of the MDS 3.0. The MDS 3.0 Individual Correction/Deletion or Move Request are distinct processes to address a few types of errors in a record in iQIES that cannot be corrected with a Modification or Inactivation Request.

Key Takeaway:
More details on manual deletion and the four required reasons in chapter 5.

Chapter 5

- Updated Data Corrections Flow Chart

P. 5-15



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Appendix A: Glossary and Common Acronyms

- Several updated definitions

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 relate to one or more quality goals for health care. These goals include care that is: effective, safe, efficient, patient-centered, equitable, and timely.

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Appendix A: Glossary and Common Acronyms

- Several updated definitions

Fall: 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).

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Appendix A: Glossary and Common Acronyms

- Major updates acronyms (additions and removals)

OBRA '87	Omnibus Budget Reconciliation Act of 1987
~~PPI~~	~~Producer Price Index~~
~~PRM~~	~~Provider Reimbursement Manual~~
PROM	Passive Range of Motion
~~QI~~	~~Quality Indicator~~
QIN	Quality Improvement Network
SB-~~PPS~~	Swing Bed-~~Prospective Payment System~~

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Questions

Thank you!

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Resources

- RAI User's Manual
  - https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual
- AAPACN Tools:
  - FY 2026 MDS Updates: At-a-Glance

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