Oct. 1, 2025: MDS Changes At-a-Glance

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This chart details key changes in the *RAI User's Manual*, version 1.20.1. Please note that not all changes are included here.

MDS Section	Overview	Key Changes	Takeaways
A	• Removed the term "Gender" • Retired A0800 • New A0810 • Replaced A1250 with A1255	• Replaced the term "Gender" with "Sex." • Replaced A0800 with A0810. • Updated language throughout. • Replaced A1250. Transportation with A1255. Transportation. ◦ Updated coding instructions and coding tips.	• CMS updated terminology. • The new transportation item is only coded on the Medicare 5-Day PPS assessment when the resident's admission entry (A1900) is less than 366 days from the ARD.
D	• Additions only	• 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. CMS expects a dash response to be rare. • 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.	• CMS clarified dash use for PHQ-2 to 9 at symptom frequency.
GG	• Added clarifications • Removed several examples for prior functioning	• Added coding tip for **prior functioning:** ◦ For the GG0100C stair activity, "by any safe means" may include a resident scooting up and down stairs on their buttocks. • Added coding tip for **prior device use:** ◦ Clinical judgment may be used to determine whether other devices meet the definition provided. • Edited the Steps for Assessment: ◦ Clarified that the definition of "helper" only applies to GG0130 and GG0170. • Added coding tip for **self-care and mobility:** ◦ 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). • Added general coding tips for **self-care and mobility:** ◦ 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. ◦ 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).	• CMS provided several clarifications focused on device use, such as using clinical judgment to identify devices and appropriately assessing usual performance when devices are used. • CMS clarified that some tasks may only occur once during the 3-day period; assessment of usual performance should be based on this occurrence. • CMS clarified that a resident can be "dependent" with walking when two helpers are required. • CMS clarified that stairs and step items do not include moving to or from the stairs or sit to stand; assessment starts with the resident standing at the stairs or step.

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GG *(continued)*		• Added coding tip for **usual performance:** ◦ If two or more helpers are required to assist the resident in completing the activity, code as 01, Dependent. • Added coding tip for **eating:** ◦ The adequacy of the resident's nutrition or hydration is not considered for GG0130A, Eating. • Added coding tips for **dressing** items: ◦ 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. • Added coding tip for **bed mobility** items: ◦ 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. • Added coding tip for **Transfer** item: ◦ If the resident uses a recliner as their "bed" (preferred or necessary sleeping surface), assess the resident's need for assistance using that sleeping surface when coding GG0170E, Chair/bed-to-chair transfer. • Added coding tips for **walking** items: ◦ 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. • Added coding tips for **stairs/steps** items: ◦ 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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J	• New definition for fall • Moved intercepted fall guidance to coding tip • Changes to injury (except major) • New definition for major injury • New example for a fall during therapy • New coding tip on pathological fractures • Two new examples for difference between pathological and traumatic fracture	• New 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. • Updated coding tip for falls: ◦ 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.* • Updated definition for 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. • Updated definition for 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. • New coding tip for major injury: ◦ Fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall. • One new example regarding a fall during therapy: ◦ 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. • Two new examples for differentiating between a traumatic vs. pathological fracture: ◦ 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.	• New fall definition includes a fall related to overwhelming external force. • CMS moved the clarification for intercepted fall excluding therapy balance test from the definition to a coding tip. • CMS clarified that the list for injury (except major) is not all-inclusive. • CMS clarified in the major injury definition that the list is not all-inclusive and expanded the list of major injury examples. • CMS clarified in the coding tip and examples the difference between pathological and traumatic fracture; pathological fracture is not considered an injury from the fall.

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K	• Clarification for weight loss and gain calculations	• Clarified steps for assessment for weight loss and 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 two visual examples; one for weight loss and one for weight gain. • Added a coding tip for both weight loss and 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.*	• CMS clarified the process of determining weight loss and gain.
M	• Clarification for present on admission	• Clarification added to Step 3: Determine "Present on Admission"; edits to number 4 item and added a 12th step: ◦ 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."*	• CMS added clarification to determine present on admission if the pressure ulcer is numerically stageable or unstageable.
N	• Replaced coding tip regarding reference materials and input from consultant pharmacist with new tips • Updated links	• New coding tips for high-risk medications: ◦ 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). ◦ Do not code flushes to keep IV access patent in N0415E, Anticoagulant.	• CMS added a tip to identify the resource facilities used to identify pharmacological classification. • CMS changed clarification from using a consultant pharmacist to the resident's pharmacist. • CMS clarified that the coding tip advising not to include flushes to keep IV access patent applies to anticoagulants.

MDS Section	Overview	Key Changes	Takeaways
O	• Updated links for vaccines • Updated examples for pneumococcal vaccine to reflect updated "up to date" guidance • O0390, Therapy Services, replaced most of O0400 • O0400 only contains the number of days respiratory therapy was administered • Most RAI guidance from O0400 moved to O0390 • Examples updated to reflect changes to O0390 • Removed O0420, Distinct Calendar Days of Therapy	• New item O0390, Therapy Services: ◦ Check boxes only if at least 15 minutes of therapy per day on one or more days in the last 7 days was received by the resident for: ▪ Speech-language pathology and audiology services ▪ Occupational therapy ▪ Physical therapy ▪ Respiratory therapy ▪ Psychological therapy • Added 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.* • Added four new examples [only one listed here]: ◦ *Resident Z's assessment has an ARD [assessment reference date] of 09/05/24. Review of the records shows Resident Z received occupational therapy on 08/30/24 for 25 minutes, 09/01/24 for 15 minutes, and 09/03/24 for 30 minutes.* ▪ **Coding:** O0390B would be **checked.** ▪ **Rationale:** Resident Z received at least 15 minutes of occupational therapy on at least one day during the observation period.	• Vaccine links and examples were updated. • CMS replaced O0400 with O0390; remove detailed therapy information from O0400 (individual minutes, concurrent minutes, group therapy, co-treat, start and end dates); the new item is a checkbox only for services received. • CMS maintained days of respiratory therapy at O0400D.
R	• Removed from draft *RAI User's Manual*	• Removed from draft *RAI User's Manual.*	• CMS finalized the removal of section R in the FY 2026 SNF PPS Final Rule.
X and Chapter 5	• Clarification on manual deletion process • New data correction decision tree	• Several edits on pages X-1, X-2, and in chapter 5, added clarification on the individual record deletion process. • Added a new "Data Correction" decision tree on page 5-15.	• CMS provided record deletion information and process clarification.
Appendix A	• New definition for QMs • Several additional definitions and acronyms added	• New definition for Quality Measures [QMs] added: ◦ 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.	• This new QM definition shifts focus from MDS-derived numeric data to outcomes.