



FY 2027 RAI Manual Updates/ OBRA Discharge Clarifications

Everything You Need to Know

Joel VanEaton, EVP Post Acute Regulatory
Affairs and Education at Broad River Rehab



APPROVAL STATEMENT DISCLOSURE

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

CONFLICT OF INTEREST DISCLOSURE

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



SUCCESSFUL COMPLETION REQUIREMENTS

- In order to obtain nursing contact hours, you must participate in the entire program and complete the entire evaluation.

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

- Contact hours for this program will not be awarded after 1 week



Learning Objectives

- Identify the sections of the RAI Manual where coding guidance has been revised
- Recognize the specific coding clarifications by section
- Understand the clarification related to the OBRA Discharge Assessment guidelines
- Apply this knowledge to facility operational practice



Resources

- [RAI manual v1.20.11](#)
- [OBRA Discharge FACT sheet](#)
- [Chapter 2: Assessment Types and Timing for the Resident Assessment Instrument \(RAI\) Training](#)

Chapter 1: Page 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 *require* additional MDS *assessments beyond the mandated assessment schedule*. For specific information on State requirements, please contact your State RAI Coordinator ([see Appendix B](#)).

Chapter 2: Page 2-6

- ***Resident Transfers During a Public Health Emergency:***
 - *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.](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/1135-waivers)

Chapter 2: Page 2-49

- Some states require providers to complete additional state-specific items (Section S) for selected assessments. Providers must ensure they follow their state requirements *for state-specific items in Section S.*
- States may also add 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.*

Chapter 3: Page 3-1

- **CHAPTER 3: OVERVIEW TO THE ITEM-BY-ITEM GUIDE TO THE MDS 3.0** The MDS is completed
- *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.*

Chapter 3: Page A-16

- **Steps for Assessment for A1005: Ethnicity**

- ***For a New Admission***

- 1. Ask the resident to select the category or categories that most closely correspond to
- 2. their ethnicity from the list in A1005, *Ethnicity*.
- 3. Ethnic category definitions are provided only if requested in order to answer the item.
- 4. Respondents should be offered the option of selecting one or more ethnic designations.
- 5. If the resident declines to respond, code Y, Resident declines to respond, and do not code based on other resources (family, significant other, or guardian/legally authorized representative or medical records).
- 6. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
- 7. Only use medical record documentation to code A1005, Ethnicity, 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.

- ***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.*
- *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.*

Chapter 3: Page A-19

- **Steps for Assessment for A1010: Race**

- ***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.
- 2. Racial category definitions are provided only if requested in order to answer the item.
- 3. Respondents should be offered the option of selecting one or more racial designations.
- 4. If the resident declines to respond, code Y, Resident declines to respond, and do not code based on other resources (family, significant other, or legally authorized representative or medical records).
- 5. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
- 6. Only use medical record documentation to code A1010, Race, 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.

- ***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.*

Chapter 3: Page C-6

- **Coding Tips (BIMS)**

- *If multiple BIMS are conducted during the look-back period, code the MDS with the BIMS conducted closest to the ARD.*

Chapter 3: Page D-7

- **Coding Tips and Special Populations (PHQ 2 to 9)**

- *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.*

Chapter 3: Page J-2

- **Coding Instructions for J0100A, *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.

Chapter 3: Page 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.

Chapter 3: Page J-25

- **Steps For Assessment for J1100: Shortness of Breath**
 - *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.*

Chapter 3: Page J-35

- **Steps For Assessment for J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent**
 - 1. If this is the first assessment *since* entry/*admission* (A0310E = 1 *and* A1700 = 1), review the medical record for the time period from the admission date to the ARD.
 - 2. If this is the first assessment *since* reentry (A0310E = 1 *and* A1700 = 2), review *the medical record for the time period from the reentry date (A1600) to the ARD.*

Chapter 3: Page M-6

- **Coding Tips for M0210: Unhealed Pressure Ulcers/Injuries**

- *Application of an advanced wound care dressing or skin substitute to a pressure ulcer is not a surgical procedure nor a graft or flap.*

Chapter 3: Page M-9

- **Step 3: Determine “Present on Admission” M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage**

- *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.”*

Chapter 3: Page M-34

- **Coding Tips for 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.*

Chapter 3: Page M-33 and M-34

- **Coding Instructions**

- **M1040D**, Open lesion(s) other than ulcers, rashes, cuts (e.g., *cancer lesion*)

- **Coding Tips for 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.

Chapter 3: Page M-35

- **Coding Tips for M1040E, Surgical wound(s)**

- *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.*

Chapter 3: Page M-40

- **Coding Tips for M1200E, Pressure ulcer/injury care**

- *Topical dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).*

Chapter 3: Page M-40

- **Coding Tips for M1200F, Surgical wound care**

- *Dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).*
- *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**.*

Chapter 3: Page M-41

- **Coding Tips for M1200I, Application of dressings to the feet (with or without topical medications)**

- *Dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).*

Chapter 3: Page O-23

- **Coding Instructions for O0390: Therapy Services**
- **Minutes of Therapy**
 - 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.

Chapter 3: Page 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-*specific* plan of care.

Chapter 3: Page O-33

- **Examples for O0390: Therapy Services**

- 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.

Chapter 3: Page O-33

- **Examples for O0390: Therapy Services**

- *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.*

Chapter 3: Page O-34

- **Steps for Assessment for O0400D2: Respiratory Therapies (Days)**

- *Complete only if O0390D, Respiratory Therapy, is checked.*
- Review the resident's medical record and consult with each of the qualified care providers to collect the information required for this item.
- *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 *during* the day.

Chapter 3: Page O-34

- **Example for O0400D2: Respiratory Therapies (Days)**

- Following a stroke *and aspiration pneumonia*, Resident F was admitted to the skilled nursing facility on 10/06/26 under *Medicare* Part A skilled nursing facility coverage. *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.*
- **Coding:** O0400D2 would be **coded 3**.
- **Rationale:** *The resident only received skilled respiratory therapy services for 15 minutes on 3 days.* Therefore, O0400D equals **3 days**.

Chapter 6: Throughout the Chapter

- CMS has added language throughout Chapter 6 to include, “Signs and Symptoms”, alongside the word “Depression” to clarify that this end split is not a diagnosis, rather an indication for further investigation.
 - **Example page 6-37:** Step 3 for evaluating the criteria for the Special Care high Category indicates the following:
 - 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[©]).

Chapter 6: Page 6-36

CATEGORY: SPECIAL CARE HIGH

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

Step #1

I6200, J1100C

Asthma, chronic obstructive pulmonary disease, *or chronic lung disease* **and** shortness of breath when lying flat

Chapter 6: Page 6-46 and 6-47

- CMS has added the following clarification for restorative impact in the Behavioral Symptoms and Cognitive Performance as well as the Reduced Physical Function PDPM categories:
 - ***Toileting programs (H0200C and H0500) do not require day/minute documentation*

OBRA Discharge Clarification



OBRA Discharge Assessment Determination



Purpose: The purpose of this fact sheet is to clarify when an OBRA Discharge assessment is required under the *MDS 3.0 RAI User's Manual* v1.20.1 and to address common areas of confusion related to emergency department (ED) visits, observation stays, and leave of absence (LOA).

FAQ

When is an OBRA Discharge assessment required?

Discharge Criteria Must Be Met (Primary Rule)

A Discharge assessment is required only when the resident meets one of the outlined criteria (Ch. 2, pg. 2-11):

- Admission to a hospital or other care setting
- Hospital observation stay greater than 24 hours
- Discharge to a private residence
- Transfer to a non-certified bed

If none of these criteria are met, a Discharge assessment is not required.

ED Visits Alone are Not a Trigger

An ED visit by itself does not trigger a Discharge assessment, regardless of duration.

A Discharge assessment is only required if the ED visit results in:

- Hospital admission, or
- Observation stay greater than 24 hours

Time spent in the ED alone is not a determining factor.

LOA Does Not Trigger Discharge

LOA guidance clarifies when an individual remains a resident, including (Ch. 2, pg. 2-14):

- Temporary absences (e.g., home visits)
- Hospital observation stays less than 24 hours (no admission)

These scenarios do not require a Discharge assessment or Entry Tracking.

Unplanned Discharge Examples are Not Triggers

Unplanned discharge examples (Ch. 2, pg. 2-41):

- Describe types of discharges
- Do not determine whether a discharge is required

Correct process:

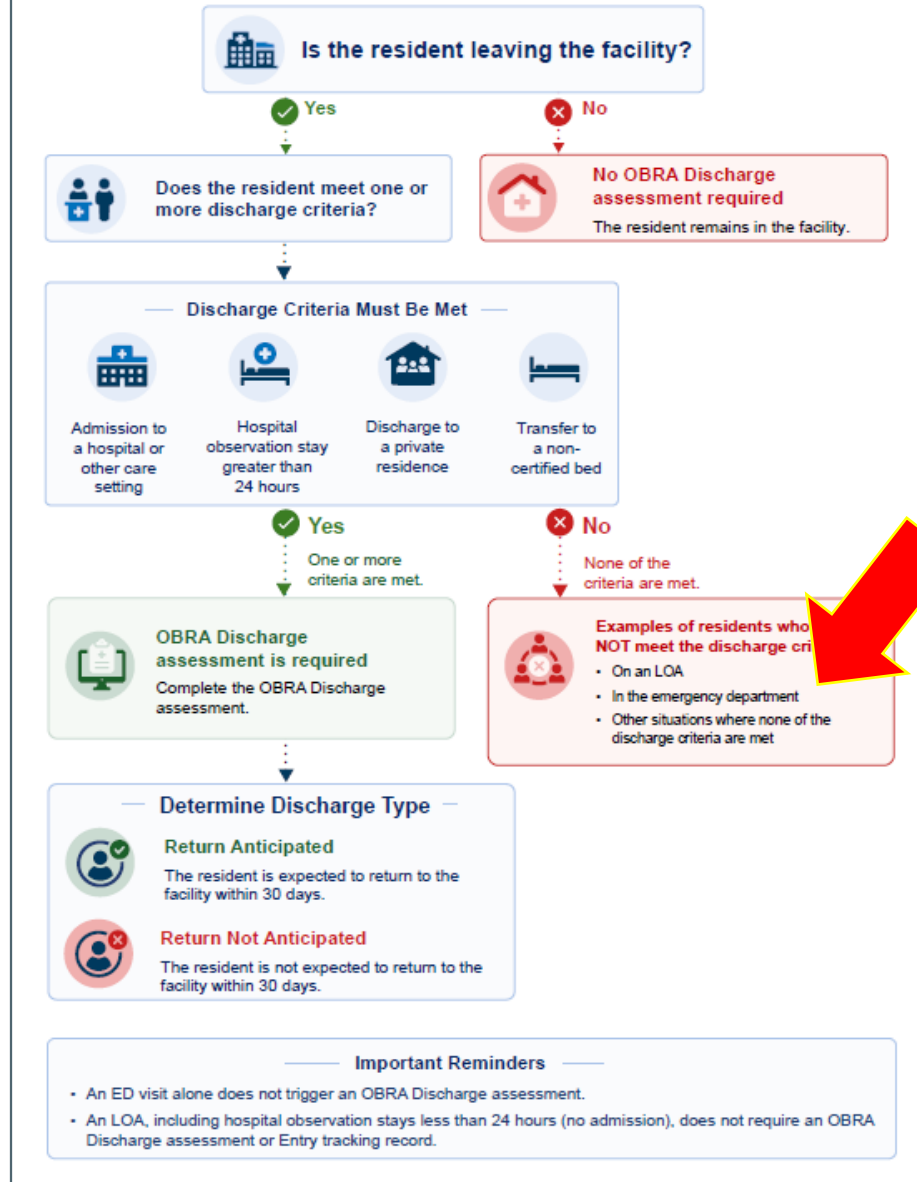
1. Determine if discharge criteria are met, then
2. Classify as planned or unplanned

A common misconception is that a resident out of the facility for more than 24 hours requires a Discharge assessment.

OBRA Discharge Clarification



OBRA Discharge Assessment Decision Tree



Next Steps

- Download a copy of the revised RAI Manual for all IDT members.
- Review these revisions together so the whole team is on the same page related to appropriate coding
- Access resources that will help the team stay up to date on how the FY 2027 changes will affect reimbursement, quality measures and care planning
- Work together to be sure that everyone involved understands the clarified OBRA discharge guidance

QUESTIONS?

