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6	6.2	6-2	Over half of the State Medicaid programs also use the MDS for their case mix payment systems. The RUG-IV system ~~replaces~~ replaced the RUG-III for Medicare starting o~~i~~n October 1, 2010. However, State Medicaid agencies have the option to continue to use the RUG-III classification systems or adopt the RUG-IV system. CMS also provides the States alternative RUG-IV classification systems with 66, 57, or 48 groups with varying numbers of Rehabilitation groups (similar to the RUG-III 53, 44, and 34 groups). States have the option of selecting the system (RUG-III or RUG-IV) with the number of Rehabilitation groups that better suits their Medicaid long-term care population. State Medicaid programs always have the option to develop nursing home reimbursement systems that meet their specific program goals. The decision to implement a RUG-IV classification system for Medicaid is a State decision. Please contact your State Medicaid agency if you have questions about your State Medicaid reimbursement system. The MDS assessment data is used to calculate the RUG-IV classification necessary for payment. The MDS contains extensive information on the resident's nursing and therapy needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses. This information is used to define RUG-IV groups that form a hierarchy from the greatest to the least resources used. Residents with more specialized nursing requirements, licensed therapies, greater ADL dependency, or other conditions will be assigned to higher groups in the RUG-IV hierarchy. Providing care to these residents is more costly and is reimbursed at a higher level.
6	6.4	6-6	**RUG-IV Group Code** The first three positions of the HIPPS code contain the RUG-IV group code to be billed for Medicare reimbursement. The RUG-IV group is calculated from the MDS assessment clinical data. See Section 6.6 for calculation details on each RUG group. CMS provides standard software, development tools, and logic for RUG-IV calculation. CMS software, or private software developed with the CMS tools, is used to encode and transmit the MDS assessment data and automatically calculates the RUG-IV group. CMS edits and validates the RUG-IV group code of transmitted MDS assessments. Skilled nursing facilities are

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			not permitted to submit Medicare Part A claims until the assessments have been accepted into the CMS database, and they must use the RUG-IV code as validated by CMS when bills are filed, except in cases in which the facility must bill the default code (AAA). See Section 6.8 for details. The following RUG-IV group codes are used in the billing process:
6	6.4	6-7	There are two different Medicare HIPPS codes that may be recorded on the MDS 3.0 in Items Z0100A (Medicare Part A HIPPS code) and Z0150A (Medicare Part A non-therapy HIPPS code). The Medicare Part A HIPPS code may consist of any RUG-IV group code. The Medicare Part A non-therapy HIPPS code is restricted to the RUG-IV groups of Extensive Services and below. ~~Which of these~~The HIPPS code~~s is~~ included on the Medicare claim depends on the specific type of assessment~~s~~ involved. The RUG ~~group~~ codes in Items Z0100A and Z0150A are validated by CMS when the assessment is submitted. If the submitted RUG code is incorrect, the validation report will include a warning giving the correct code, and the facility must use the correct code in the HIPPS code on the bill. **AI Code** The last two positions of the HIPPS code represent the Assessment Indicator (AI), identifying the assessment type. The AI coding system indicates the different types of assessments that define different PPS payment periods and is based on the coding of Item A0310. CMS p~~P~~rovides standard software, development tools, and logic for AI code calculation. CMS software, or private software developed with the CMS tools, automatically calculates the AI code. The AI code is validated by CMS when the assessment is submitted. If the submitted AI code is incorrect on the assessment, the validation report will include a warning and provide the correct code. The facility is to use the correct AI code in the HIPPS code on the bill. The code consists of two digits, which are defined below. In situations when the provider is to bill the default code, such as a late assessment, the AI provided on the validation report is to be used along with the default code, AAA, on the Medicare claim. Refer to the **Medicare Claims Processing Manual**, Chapter 6, for

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			detailed claims processing requirements and policies. **First AI Digit** The first digit of the AI code identifies scheduled PPS assessments that establish the RUG payment rate for the standard PPS scheduled payment periods. These assessments are PPS 5-day, 14-day, 30-day, 60-day, 90-day, and readmission/return. The Omnibus Budget Reconciliation Act (OBRA 1987) required assessments are also included, because they can be used under certain circumstances for payment (see Section 6.8). Table 2 displays the first AI code for each of the scheduled PPS assessment types and the standard payment period for each assessment type.
6	6.4	6-8	* These are the payment periods that apply when only the scheduled Medicare-required assessments are ~~completed~~performed. These are subject to change when unscheduled assessments used for PPS are ~~completed~~performed, e.g., significant change in status, or when other requirements mus be met.
6	6.4	6-8	**Second AI Digit** The second digit of the AI code identifies unscheduled assessments used for PPS. Unscheduled PPS assessments are conducted in addition to the required standard scheduled PPS assessments and include the following OBRA unscheduled assessments: Significant Change in Status Assessment (SCSA) and Significant Correction to Comprehensive Assessment (SCPA), as well as the following PPS unscheduled assessments: Start of Therapy Other Medicare-required Assessment (OMRA), End of Therapy OMRA, Change of Therapy OMRA, and Swing Bed Clinical Change Assessment (CCA). Unscheduled assessments may be required at any time during the resident's Part A stay. They may be ~~completed~~performed as separate assessments or combined with other assessments. ~~and, in some instances, will replace the scheduled PPS assessment.~~
6	6.4	6-8 & 6-9	Special requirements apply when there are multiple assessments within one PPS scheduled assessment window. If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment, and

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			the ARD of the scheduled assessment is not set for a day that is prior to the ARD of the unscheduled assessment, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to the A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the requirements for both the scheduled and unscheduled assessments. A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window—the scheduled assessment must be combined with the unscheduled assessment using the appropriate ARD for the unscheduled assessment. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the resident's clinical condition and service needs. More details about combining PPS assessments are provided in Chapter 2 of this manual and in Chapter 6, Section 30.3 of the Medicare Claims Processing Manual (CMS Pub. 100-04) available on the CMS web site. Examples for combining PPS assessments are as follows: • If the ARD for an SCSA is set for Day 13 (within the Day 13 to Day 18 window for the 14-Day assessment), then the 14-Day assessment cannot be later in the window. The 14-Day assessment must be combined with the SCSA with an ARD of Day 13. On this combined assessment, Item A0310B is set to 02 indicating the 14-Day assessment and Item A0310A is set to 04 indicating the SCSA. • If the 14-Day assessment has an ARD of Day 15, then a Start of Therapy OMRA may occur later in the window (Day 16 to Day 18). If there are uncombined scheduled and unscheduled assessments in the assessment window, then the scheduled assessment must have the earliest ARD.
6	6.4	6-9	• An End of Therapy OMRA Medicare Non-Therapy RUG (Z0150A) takes effect on the day after ~~all therapy ended~~the last day of therapy provided.
6	6.4	6-9 &	• A Change of Therapy OMRA Medicare Therapy RUG

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		6-10	(item Z0100A) takes effect on Day 1 of the Change of Therapy observation period (see Chapter 2 discussion of the Change in Therapy OMRA). Examples: 1. When rehabilitation therapy begins during the middle of a Medicare Part A stay, a Start of Therapy OMRA may optionally be performed within 5 to 7 days after the earliest start of therapy date (items O0400A5, O0400B5, or O0400C5). The Start of Therapy OMRA changes the RUG payment rate previously established by a previous PPS assessment from the earliest start of therapy date through the end of the standard payment period. **Consider Example 1**. • EXAMPLE 1. The 14-Day assessment is performed with an ARD on Day 14. This assessment establishes the RUG payment for Days 15 through 30. Rehabilitation therapy starts on Day 18 and a Start of Therapy OMRA is performed with an ARD 6 days later on Day 24. The Start of Therapy OMRA will change the RUG payment starting on Day 18 until Day 30 (the end of the standard payment period). 2. The unscheduled Start of Therapy assessment changes the RUG payment rate for days prior to the ARD of that Start of Therapy assessment. Because of this policy, there are cases where a Start of Therapy OMRA can change the RUG payment rate for an entire standard payment period. **Consider Example 2**. • EXAMPLE 2. The scheduled 14-day assessment is performed with ARD on Day 14 of the stay. This 14-day assessment establishes the RUG payment rate for the standard Day 15 to Day 30 payment period. Rehabilitation therapy had started on Day 13. The facility opts to perform a Start of Therapy OMRA with ARD on Day 19 (6 days after the start of therapy). This Start of Therapy OMRA will change the RUG payment beginning with Day 13 through Day 30 (the end of the standard payment period). In this case, the HIPPS code from the

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			Start of Therapy OMRA will be used for the entire Day 15 through Day 30 payment period and the 14-day assessment will not be used for billing. If the entire set of claims for the stay is reviewed, then there will be no HIPPS code with an Assessment Indictor code for the 14-day assessment. This does not present a SNF billing compliance problem. Examination of all the assessments and claims will indicate that a 14-day assessment was performed but that the Start of Therapy OMRA controlled the payment rate for the entire Day 15 to Day 30 payment period. Example 2 also illustrates that there are cases where a single Start of Therapy OMRA can change the RUG payment rate in 2 separate payment periods. In Example 2, the Start of Therapy OMRA changes the RUG payment rate for the last 2 days (Days 13 and 14) of the 5-Day assessment payment period and all of the days (Days 15 through 30) of the 14-Day assessment payment period.
6	6.4	6-10	3. When all rehabilitation therapy ends, an End of Therapy OMRA must be performed within 1 to 3 days after the end of therapy, in order to establish a Medicare Non-Therapy RUG (Z0150A) for billing beginning with the day after therapy ended until the end of the current payment period. After the End of Therapy OMRA, a Medicare RUG in the Rehabilitation Plus Extensive or Rehabilitation groups should not be billed unless rehabilitation therapy starts again. **Example ~~1~~ 3** presents the most common situation.
6	6.4	6-11	• EXAMPLE ~~1~~3. Rehabilitation therapy ends on Day 20 of a Medicare stay. An End of Therapy OMRA is performed with ARD on Day 22 and the Medicare Non-Therapy RUG (Z0150A) is billed from Day 21 (day after the last day therapy ~~end~~provided) to the end of the current payment period of Day 30. 4. Consider Example ~~2~~ 4 where a scheduled PPS assessment has set the payment rate for the next payment period and then an End of Therapy OMRA is conducted before the beginning of ~~the next~~that payment

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			period. • EXAMPLE ~~2~~4. The PPS 30-day assessment is performed with ARD on Day 27~~5~~ to establish a Medicare RUG (Z0100A) for the Day 31 to Day 60 payment period. Rehabilitation therapy ends on Day 26 and an End of Therapy OMRA is performed with ARD on Day 29~~7~~. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day ~~27~~27 through Day 30. The Medicare ***Non-Therapy*** RUG from the 30-day assessment is then billed for the next payment period. The Non-Therapy RUG from the 30-day assessment is used since all therapy had~~s~~ previously ended. 5. Consider Example ~~3~~ 5 where an End of Therapy OMRA is performed and followed within a few days by a scheduled PPS assessment. • EXAMPLE ~~3~~5. The End of Therapy OMRA assessment is performed with ARD on Day 25 since therapy ended on Day 24. The PPS 30-day assessment is then performed with ARD on Day 28~~6~~ to establish a Medicare RUG for the Day 31 to Day 60 payment period. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 25~~6~~ through Day 30. The Medicare ***Non-Therapy*** RUG (Z150A) from the 30-day assessment is then billed for the next payment period, Day 31 through Day 60. The Non-Therapy RUG from the 30-day assessment is used since all therapy has previously ended. The normal Medicare RUG (Z0100A) should not be used since it may contain a Rehabilitation Plus Extensive or Rehabilitation group RUG, because the 7-day reference period extends back before therapy had ended.
6	6.4	6-11	~~Consider Example 4 where an End of Therapy OMRA is performed and followed within a few days by a scheduled PPS assessment during the scheduled assessment grace~~

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			~~days.~~ ~~EXAMPLE 4. The End of Therapy OMRA assessment is performed with ARD on Day 32 since therapy ended on Day 31. The PPS 30-day assessment is then performed with ARD on Day 34 (during the grace days) to establish a Medicare RUG for the Day 31 to Day 60 payment period. The normal Medicare RUG (Z0100A) from the 30-day assessment establishes the payment rate for the Day 31 to Day 60 payment period. However that RUG which may be in a Rehabilitation Plus Extensive or Rehabilitation group is only billed for Day 31, since the End of Therapy OMRA will reset payment to a Non-Therapy RUG (Z0150A) beginning on Day 32 (the day after therapy ended) through the remainder of the current payment period ending with Day 60. An unscheduled assessment replaces a scheduled assessment when the unscheduled assessment is in the scheduled assessment window (including grace days) and the scheduled assessment has not already been performed. When an unscheduled assessment replaces a scheduled PPS assessment, the unscheduled assessment establishes the payment rate for the standard payment period normally associated with the scheduled PPS assessment (as long as all coverage criteria continue to be met). The assessment should indicate both the scheduled PPS assessment being replaced and the type of the unscheduled assessment replacing the scheduled PPS assessment. For example, if an SCSA replaces the PPS 30-day assessment, then MDS Item A0310A is coded 04, indicating an SCSA, and Item A0310B is coded 03, indicating a PPS 30-day assessment; thus the SCSA is replacing the PPS 30-day assessment. In this case, the first AI digit will be set to 3, and this assessment will establish the payment rate for the Day 31 through 60 standard payment period. If the ARD also falls within the ARD window of a scheduled assessment, the assessment may also impact the payment period for the 14-day assessment (days 15-30). Refer to the **Medicare Claims Processing Manual**, Chapter 6, and Chapter 2 of this manual for details.~~
6	6.4	6-11 & 6-12	6. Consider Example 6, a complicated example where an End of Therapy OMRA is performed, followed shortly by a scheduled PPS assessment, and then therapy is resumed at the prior level and this is reported with the Resumption of Therapy items (O0450A and O0450B) being added to the

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			End of Therapy OMRA converting it to an End of Therapy OMRA reporting Resumption of Therapy (EOT-R). • EXAMPLE 6. The End of Therapy OMRA has an ARD on Day 26 with the last day of therapy being Day 24. The PPS 30 Day assessment is then performed on Day 27 (the first day of the ARD window) to establish payment with the Medicare RUG (Z0100A) for Days 31-60. Therapy then resumes at the prior level and the EOT-R items (O0450A, and O0450B) indicate a resumption of therapy date of Day 28. The EOT OMRA would establish payment at a Medicare Non-Therapy RUG (Z0150A) for Days 25-27 and Resumption of Therapy reporting would reestablish payment from Day 28 through Day 30 (the end of the payment period) at the same Medicare RUG (Z0100A) provided on the resident's most recent PPS assessment used to establish payment prior to Day 25. The PPS 30-day assessment would then set the payment at the Medicare RUG (Z0100A) for the standard Day 31 to 60 payment period.
	6-4	6-11	~~7. Another example of an unscheduled assessment replacing a scheduled PPS assessment is a Start of Therapy OMRA replacing the PPS 14-day assessment. In this case, Item A0310B is coded 02, indicating a PPS 14-day assessment, and Item A0310C is coded 01, indicating the Start of Therapy OMRA. The Start of Therapy OMRA is replacing the PPS 14-day assessment. The first AI digit will be set to 2, and this assessment will establish the payment rate for the Day 15 through 30 standard payment period. Depending on the day of stay that the ARD is set, the assessment may impact the payment period for the 5-day assessment (days 1-14). Refer to the **Medicare Claims Processing Manual**, Chapter 6, and Chapter 2 of this manual for details.~~
6	6.4	6-12	When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.

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			The first Change of Therapy OMRA evaluation occurs on Day 7 after the most recent assessment ARD (except in cases where the last assessment is an EOT-R, as outlined in Chapter 2) and the provision of therapy services are evaluated for the first Change of Therapy OMRA observation period (Day 1 through Day 7 after the assessment ARD). If the provision of therapy services during this 7 day period no longer reflects the RUG-IV classification category on the most recent PPS assessment (as described in Chapter 2), then a Change of Therapy OMRA must be performed with the ARD on Day 7 of the COT observation period. If the provision of therapy services are reflected by the most recent PPS assessment RUG category classification, a Change in Therapy OMRA is not performed on Day 7 and changes in the provision of therapy services would next be evaluated on Day 14 after the most recent assessment ARD using the second Change of Therapy OMRA observation period (Day 8 through Day 14 after the assessment ARD). If a different RUG-IV classification category results for Day 14, then a Change of Therapy OMRA must be performed with an ARD on Day 14, which is Day 7 of that COT observation period. If the provision of therapy services are reflected by the most recent PPS assessment RUG category classification, a Change in Therapy OMRA is not performed on Day 14 and the evaluation of the change in therapy services provided would next be evaluated on Day 21 after the most recent assessment ARD using the third Change of Therapy OMRA observation period (Day 15 through Day 21 after the assessment ARD). This process continues until a new scheduled or unscheduled PPS assessment is performed. When a new PPS assessment is performed (Change of Therapy OMRA, any other unscheduled PPS assessment, or scheduled PPS assessment), then the COT OMRA evaluation process restarts. If at any point, rehabilitation therapy ends before the last day of a Change of Therapy OMRA observation period and an End of Therapy OMRA is required, then the change of therapy evaluation process ends until the next PPS assessment which includes the resident receiving skilled therapy services again. 7. Example 7 presents a case where a Change in Therapy

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			OMRA is performed. • EXAMPLE 7. The 30-day assessment is performed with the ARD on Day 30, and the provision of therapy services are evaluated on Day 37. It is determined that the therapy services provided were reflected by the RUG-IV classification category on the most recent PPS assessment and therefore, no Change of Therapy OMRA is performed on Day 37. When the provision of therapy services are next evaluated on Day 44, it is determined that a different Rehabilitation category results and a Change in Therapy OMRA is performed with ARD on Day 44. The Change of Therapy OMRA will change the RUG payment beginning on Day 38 (the first day of the Change of Therapy OMRA observation period). The Change of Therapy OMRA evaluation process then restarts with this Change of Therapy OMRA. 8. If a new PPS assessment occurs before the last day of a Change of Therapy OMRA observation period, then a Change of Therapy OMRA is not performed for that observation period. Example 8 illustrates this case. • EXAMPLE 8. An SCSA is performed with ARD on Day 10. An evaluation for the Change of Therapy OMRA would occur on Day 17 but the 14-Day assessment intervenes with ARD on Day 15. A Change of Therapy OMRA is not performed on Day 17. Rather the COT OMRA evaluation process is restarted with the 14-day assessment with ARD on Day 15. Day 1 of the next COT observation period is Day 16 and the new COT OMRA evaluation would be done on Day 22. 9. Example 9 illustrates that the COT OMRA evaluation process ends when all rehabilitation therapy ends before the end of a Change in Therapy OMRA observation period. • EXAMPLE 9. The 14-Day assessment is performed with the ARD on Day 14. The first COT OMRA evaluation would normally happen on Day 21. However, all therapy ends on Day 20. The ARD for an EOT OMRA is set for Day 21 to reflect the discontinuation of therapy services. No Change in Therapy OMRA is performed on Day 21 and the

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			change in therapy evaluation process is discontinued.
6	6.4	6-13	~~Whether an unscheduled assessment is a separate assessment (i.e., not combined with another assessment), is combined with another assessment, or replaces a scheduled PPS assessment, the unscheduled assessment impacts the payment for days within a standard payment period.~~
6	6.4	6-13 through 6-15	TABLE 3 CHANGES: • If the ARD of the unscheduled assessment is a grace day of a scheduled PPS assessment: — Use the Medicare RUG (Z0100A) from the start of the standard payment period~~for the scheduled PPS assessment~~. End of Therapy OMRA **not reporting** Resumption of Therapy; **whether or not** combined with unscheduled OBRA assessment and **whether or not** combined with Swing Bed CCA Do NOT use if • Combined with Start of Therapy OMRA • Medicare Short Stay assessment • End of Therapy OMRA **reporting** Resumption of Therapy (EOT-R) Start of Therapy OMRA combined with End of Therapy OMRA **not reporting** Resumption of Therapy Do NOT use if • Medicare Short Stay assessment • Combined with unscheduled OBRA • Combined with Swing Bed CCA • End of Therapy OMRA reporting Resumption of Therapy (EOT-R) Start of Therapy OMRA combined with End of Therapy OMRA **not reporting** Resumption of Therapy and combined with either an unscheduled OBRA assessment **or** Swing Bed CCA Do NOT use if 1. Medicare Short Stay assessment 2. End of Therapy OMRA reporting Resumption of Therapy (EOT-R)

6	6.4	6-16	Added Text to Table 3 (see below)

Table 3. Assessment Indicator Second Digit Table (continued)

Second Digit Values	Assessment Type	Impact on Standard Payment Period
A	End of Therapy OMRA **reporting** Resumption of Therapy (EOT-R); **whether or not** combined with unscheduled OBRA assessment and **whether or not** combined with Swing Bed CCA Do NOT use if • Combined with Start of Therapy OMRA • Medicare Short Stay assessment	• Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date (speech-language pathology services in O0400A6, occupational therapy in O0400B6, or physical therapy in O0400C6) through the day before the resumption of therapy date (O0450B). • Use the Medicare RUG (Z0100A) from the assessment (used for SNF/PPS) immediately preceding this End of Therapy OMRA, and bill this RUG from the resumption of therapy date (O0450) through the end of the standard payment period.
B	Start of Therapy OMRA combined with End of Therapy OMRA **reporting** Resumption of Therapy (EOT-R) Do NOT use if • Medicare Short Stay assessment • Combined with unscheduled OBRA • Combined with Swing Bed CCA	• If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date. — Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date through the day before the resumption of therapy date (O0450B). — Use the unscheduled assessment Medicare RUG (Z0100A) from the resumption of therapy date through the end of the standard payment period. • If unscheduled assessment does not give a therapy group Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.
C	Start of Therapy OMRA combined with End of Therapy OMRA **reporting** Resumption of Therapy (EOT-R) and combined with either an unscheduled OBRA assessment **or** Swing Bed CCA Do NOT use if • Medicare Short Stay assessment	• If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date. — Use the unscheduled assessment non-therapy RUG (Z0150A) from the day after the latest therapy end date through the day before the resumption of therapy date (O0450B). — Use the unscheduled assessment Medicare RUG (Z0100A) from the resumption of therapy date through the end of the standard payment period. • If unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.
D	Change of Therapy OMRA; **whether or not** combined with unscheduled OBRA assessment and **whether or not** combined with Swing Bed CCA	• Use the unscheduled assessment Medicare RUG (Z0100A) from the first day of the Change of Therapy OMRA observation period through the end of the standard payment period. • Note that a Change in Therapy OMRA cannot be combined with a 5-day or readmission/return assessment.

6	6.4	6-17	The information presented in the preceding table illustrates the impact of one unscheduled PPS assessment within a standard payment period. If there are additional unscheduled PPS assessments, then there may be additional impacts to the standard payment period. Refer to Medicare Claims Processing Manual~~, Chapter 6,~~ and Chapter 2 of this manual for details.
6	6.4	6-17	When a Start of Therapy OMRA is combined with a scheduled PPS assessment, any OBRA assessment, or a Swing Bed CCA, and the index maximized RUG-IV classification (Item Z0100A) is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will not be accepted by CMS. In these instances, the provider must still complete and submit an assessment that is accepted by CMS in order to be in compliance with OBRA and/or Medicare regulations.
6	6.4	6-18	1. **The assessment must be a Start of Therapy OMRA (A0310C = 1).** This assessment may be ~~completed~~ performed alone or combined with any OBRA assessment or combined with a PPS 5-day or readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but not combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility. 2. **A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been ~~completed~~performed.** The PPS 5-day or readmission/return assessment may be ~~completed~~ performed alone or combined with the Start of Therapy OMRA.
6	6.4	6-19	~~●~~1. 15-29 average... ~~●~~2. 30-64 average... ~~●~~3. 65-99 average... ~~●~~4. 100-143 average... ~~●~~5. 144 or greater average...
6	6.5	6-22	**Physician Certification** The attending physician or a physician on the staff of the skilled nursing home who has knowledge of the case—or a nurse practitioner (NP), physician assistant (PA), or clinical

			nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with the physician—must certify and then periodically recertify the need for extended care services in the skilled nursing home.
6	6.6	6-23	**Index Maximizing Classification.** Index maximizing classification is used in Medicare PPS (and most Medicaid payment systems) to select the RUG-IV group for payment. There is a designated Case Mix Index (CMI) that represents the relative resource utilization for each RUG-IV group. For index maximizing, first determine all of the RUG-IV groups for which the resident qualifies. Then, from the qualifying groups, choose the RUG-IV group that has the highest CMI. For Medicare PPS, the index maximizing method uses the CMIs effective ~~with RUG-IV implementation on October 1, 2010~~for the appropriate Federal Fiscal Year.
6	6.6	6-25	For Speech-Language Pathology Services (Items at O0400A), Occupational Therapy (Items at O0400B), and Physical Therapy (Items at O0400C), the MDS 3.0 separately captures minutes that the resident was receiving individual, concurrent, and group therapy (see Chapter 3, Section O for definitions) during the last 7 days. For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy. ~~To calculate the RUG, t~~The total minutes used for RUG-IV classification include all minutes in individual therapy, one-half of the minutes in concurrent therapy, and ~~all minutes~~ all minutes in group therapy for FY2011 Medicare Part A and non-Medicare classification. Beginning with federal FY2012 Medicare Part A classification, the group time is allocated among 4 residents and only one-fourth of the minutes of group time are included for the resident in the total minutes for RUG-IV classification. For Medicare Part A (both FY2011 and FY2012) there is a limitation that the group minutes cannot exceed 25% of the total minutes, a limitation that is applied by the grouper software. This limitation is applied after allocation of group minutes for FY2012 Medicare in FY2012 but after no allocation of group minutes for FY2011 Medicare. ~~Such a limitation may also be used for other payment systems.~~
6	6.6	6-25	Add the individual minutes (O0400A1~~),~~) and one-half of the concurrent minutes (O0400A2)~~,~~. If classification is for Medicare for FY2011~~and the~~ add all of the group minutes

			(O0400A3) and record as Total Minutes. Otherwise beginning with FY 2012, add one-quarter of the group minutes and record as Total Minutes.
6	6.6	6-25	When the 25% group therapy limitation applies (i.e., for Medicare Part A residents for FY2011 or FY2012), calculate the adjusted total minutes as follows: If total group minutes (O0400A3) for FY2011 Medicare classification or allocated group minutes (one-quarter) beginning with FY2012 Medicare classification divided by Total Minutes (using group minutes allocation only for Medicare FY2012 classification) is greater than 0.25, then add individual minutes (O0400A1) and one-half of concurrent minutes (O0400A2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.
6	6.6	6-26	~~Add the individual minutes (O0400B1), one-half of the concurrent minutes (O0400B2), and the group minutes (O0400B3) and record as Total Minutes.~~ Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). If classification is for Medicare for FY2011 add all of the group minutes (O0400B3) and record as Total Minutes. Otherwise beginning with FY 2012, add alone-quarter of the group minutes and record as Total Minutes.
6	6.6	6-26	When the 25% group therapy limitation applies (i.e., for Medicare Part A residents for FY2011 or FY2012), calculate the adjusted total minutes as follows: If total group minutes (O0400B3) for FY2011 Medicare classification or allocated group minutes (one-quarter) for FY2012 Medicare classification divided by Total Minutes (using group minutes allocation only for Medicare FY2012 classification) is greater than 0.25, then add individual minutes (O0400B1) and one-half of concurrent minutes (O0400B2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.~~If group minutes (O0400B3) divided by Total Minutes are greater than 0.25, then add individual minutes (O0400B1) and one-half of concurrent minutes (O0400B2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.~~
6	6.6	6-26	Add the individual minutes (O0400C1) and one-half of the concurrent minutes (O0400C2). If classification is for Medicare for FY2011 add all of the group minutes (O0400C3) and record as Total Minutes. Otherwise

			beginning with FY 2012, add one-quarter of the group minutes and record as Total Minutes.~~Add the individual minutes (O0400C1), one-half of the concurrent minutes (O0400C2), and the group minutes (O0400C3) and record as Total Minutes.~~
6	6.6	6-26	When the 25% group therapy limitation applies (i.e., for Medicare Part A residents for FY2011 or FY2012), calculate the adjusted total minutes as follows:
6	6.6	6-26	If total group minutes (O0400C3) for FY2011 Medicare classification or allocated group minutes (one-quarter) for FY2012 Medicare classification divided by Total Minutes (using group minutes allocation only for Medicare FY2012 classification) is greater than 0.25, then add individual minutes (O0400C1) and one-half of concurrent minutes (O0400C2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.~~If group minutes (O0400C3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400C1) and one-half of concurrent minutes (O0400C2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.~~
6	6.6	6-27 & 6-28	Mrs. D., whose stay is covered under SNF PPS, received the following rehabilitation services during FY2012 (group therapy time is allocated) as follows: Calculate total SLP minutes = 110 + 99/2 + 100/4 = ~~259.5~~184.5 (retain the decimal). Check group proportion (after group allocation) = (100/4)/~~259.5~~184.5 = 0.~~385~~136. Do not ~~Adjust~~ adjust SLP minutes for Medicare Part A since group proportion is not greater than .25. Use unadjusted total SLP minutes. **~~Adjusted~~ Total Speech-Language Pathology Services Minutes** = ~~[(110 + 99/2) x 4]/3 = **212.6666***~~**184.5** (retain the decimal). Group minutes = ~~80~~ 320 (Item O0400B3). Calculate total OT minutes = 78 + 79/2 + ~~80~~ 320/4 = 197.5 (retain the decimal). Check group proportion = ~~80~~(320/4)/197.5 = 0.405. Adjust OT minutes for Medicare Part A since group proportion is greater than .25. **Adjusted Occupational Therapy Minutes** = [(78 + 79/2) x 4]/3 = **156.6666** (retain the decimal).

			Group minutes = ~~94~~ 376 (Item O0400C3). Calculate total PT minutes = 92 + 93/2 + 376/4 = 232.5 (retain the decimal). Check group proportion = ~~94~~(376/4)/232.5 = 0.404. Sum SLP, OT and PT ~~adjusted~~ minutes after any adjustment = ~~212.6666~~184.5 + 156.6666 + 184.6666 = ~~553.9998~~525.8332 Drop decimals = **~~553~~ 525 minutes**
6	6.6	6-29	1. **The assessment must be a Start of Therapy OMRA (Item A0310C = 1).** This assessment may be ~~completed~~performed alone or combined with any OBRA assessment or combined with a PPS 5-day or readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but should not be combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility. 2. **A PPS 5-day (Item A0310B = 01) or readmission/return assessment (A0310B = 06) has been ~~completed~~performed.** The PPS 5-day or readmission/return assessment may be ~~completed~~performed alone or combined with the Start of Therapy OMRA.
6	6.6	6-49 & 6-50	~~•~~1. The Medicare RUG-IV group reported in Item Z0100A should be ***adjusted to AAA*** (the default group), the assessment should marked as invalid, and the assessment should be barred from submission. The Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system will ***reject the assessment*** if submitted. ~~•~~1. The Medicare Non-Therapy RUG-IV group reported in Item Z0150A should be ***adjusted to AAA*** (the default group). ~~•~~1. When an SOT OMRA (MDS Item A0310C = 1) is ***not combined*** with an OBRA assessment or other type of PPS assessment, then an RUG-IV classification below the Rehabilitation Plus Extensive and Rehabilitation categories should be ***adjusted to AAA*** (the default group).

6	6.7	6-51	Requirements and policies for SNF PPS are described in greater detail in the **Medicare Benefit Policy Manual**. Here are some situations that the SNF may encounter that may impact Medicare Part A SNF coverage for a resident, affect the PPS assessment schedule, or impact the reimbursement received by the SNF.
6	6.7	6-51	An elapsed period of more than 30 days is permitted for starting SNF Part A services when a resident's condition makes it inappropriate to begin an active course of treatment in a SNF immediately after a qualifying hospital stay discharge. It is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame, and it is medically predictable at the time of hospital discharge that the beneficiary will require SNF level of care within a predetermined time period (for more detailed information see Chapter 8 of the **Medicare Benefit Policy Manual**). For example, a beneficiary is admitted to the SNF after a qualifying hospital stay for an open reduction and internal fixation of a hip. It is determined upon hospital discharge that the beneficiary is not ready for weight-bearing activity but will most likely be ready in 4-6 weeks. The physician writes an order to start therapy when the beneficiary is able to tolerate weight bearing. Once the resident is able to start therapy, the Medicare Part A stay begins, and the Medicare-required 5-day assessment will be ~~completed~~performed . Day 1 of the stay will be the first day on which the resident starts therapy services.
6	6.7	6-51	In the situation in which a beneficiary is discharged from SNF Medicare Part A services and later requires SNF Part A skilled level of care services, the resident may be eligible for Medicare Part A SNF coverage if the following criteria are met:
6	6.8	6-52	**Early Assessment** An assessment must be completed according to the designated Medicare PPS assessment schedule. If a scheduled Medicare-required assessment or an OMRA is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-day assessment with an ARD of Day 12~~0~~ (1 day early) would be

			paid at the default rate for the first day of the payment period that begins on day 15.
6	6.8	6-53	If the SNF fails to set the ARD prior to the end of the last day of the ARD window, including grace days, and as a result a Medicare-required assessment does not exist in the QIES ASAP for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP. When an assessment does not exist in the QIES ASAP, there is not an assessment based RUG the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid assessment that is accepted into the QIES ASAP. The provider must bill the RUG category that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, an assessment may not be ~~completed~~performed .
6	6.8	6-53	1. The stay is less than 8 days within a spell of illness, 2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial, 3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A, ~~3~~4. The SNF is notified on an untimely basis of the revocation of a payment ban, ~~4~~5. The beneficiary requests a demand bill, or ~~5~~6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan. In situations 2-6~~5~~, the provider may use the OBRA Admission assessment to bill for all days of covered care associated with Medicare-required 5-day and 14-day assessments, even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment. ~~(~~T~~t~~he ARD of the OBRA Admission assessment may be before or during the Medicare stay and does not have to fall within the ARD window of the 5-day or 14-day assessment.~~) to bill for all days of covered care associated with Medicare-required 5-day and 14-day assessments, even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment.~~
6	6.8	6-54	**ARD Outside the Medicare Part A SNF Benefit**

			A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a PPS assessment. For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in his/her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the RUG category associated with the assessment.
6	6.8	6-54	~~**6.9** {placeholder for future insertion}~~