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6	6.4	6-10	1. When rehabilitation therapy begins during the middle of a Medicare Part A stay, a Start of Therapy OMRA may optionally be performed with an ARD set for 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**.
6	6.4	6-10 & 6-11	3. When all rehabilitation therapy ends, an End of Therapy OMRA must be performed with an ARD set for 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 3** presents the most common situation.
6	6.4	6-11 & 6-12	• EXAMPLE 5. The End of Therapy OMRA assessment is performed with an ARD on Day 25 since therapy ended on Day 24. The PPS 30-day assessment is then performed with ARD on Day 28 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 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. • 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 with an ARD 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

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			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	6.4	6-12 & 6-13	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~~COT ~~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~~reflective ~~the~~of the most recent PPS assessment RUG category classification, a Change ~~in Therapy~~of 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~~COT 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, and payment is set retroactively back to the beginning of that COT observation period. If the provision of therapy services are ~~reflected by~~reflective ~~the~~of the most recent PPS assessment RUG category classification, a Change ~~in Therapy~~of Therapy OMRA is not performed with an ARD 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~~COT ~~OMRA~~ observation

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			period (Day 15 through Day 21 after the assessment ARD). This process continues until the next scheduled or unscheduled PPS assessment used for payment.~~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 the day following the ARD of that intervening assessment. If at any point, rehabilitation therapy ends before the last day of a ~~Change of Therapy OMRA~~COT observation period and an End of Therapy OMRA is ~~required~~performed with an ARD set for on or prior to Day 7 of the COT observation period, then the change of therapy evaluation process ends until the next PPS assessment used for payment ~~which~~ reflecting the utilization of skilled therapy services. ~~includes the resident receiving skilled therapy services again~~. 7. Example 7 presents a case where a Change ~~in Therapy~~of Therapy 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~~reflective of the RUG-IV classification category on the most recent PPS assessment and therefore, no Change of Therapy OMRA is performed ~~on~~ with an ARD set for 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~~of Therapy OMRA is performed with an ARD set for ~~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~~COT observation period). The Change of Therapy OMRA evaluation process then restarts with this Change of Therapy OMRA. 8. If a new PPS assessment used for payment occurs with an ARD set for on or prior to ~~before~~ the last day of a ~~Change of Therapy OMRA~~COT observation period, then a Change of Therapy OMRA is not ~~performed~~ required for that observation period. Example 8

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			illustrates this case. • EXAMPLE 8. An SCSA is performed with an ARD ~~on~~ of 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~~ with an ARD 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~~COT 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~~ of Therapy OMRA is performed with an ARD on Day 21 and the change ~~in~~ of therapy evaluation process is discontinued.
6	6.6	6-26	**STEP # 2** Calculate the total minutes for occupational therapy as follows: 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~~one-quarter of the group minutes and record as Total Minutes. Total Minutes* = _____
6	6.6	6-31	**STEP # 3** • **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

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			1. In the past 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 720 minutes or more 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~see page 6-19~~21~~) of 144 minutes or more
6	6.6	6-32 & 6-33	• **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied) 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 500 minutes or more **and** At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~see page 6-~~21~~19) of between 100 and 143 minutes • **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied) 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 325 minutes or more **and** At least 1 discipline (O0400A4, O0400B4, or O0400C4) for at least 5 days 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~see page 6-~~21~~19) of between 65 and 99 minutes • **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied) 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 150 minutes or more **and** At least 5 days of any combination of the three

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			disciplines (O0400A4 plus O0400B4 plus O0400C4) 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~see page 6-~~21~~19) of between 30 and 64 minutes • **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied): 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 45 minutes or more **and** At least 3 days of any combination of the 3 disciplines (O0400A4, plus O0400B4 plus O0400C4) **and** Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~ see page 6-~~21~~19) of between 15 and 29 minutes
6	6.6	6-34 to 6-36	**STEP # 1** A. **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied) 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 720 minutes or more **and** One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days **and** A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~ see page 6-~~21~~19) of 144 minutes or more

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			B. **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied) 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 500 minutes or more **and** At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~ see page 6-~~21~~19) of between 100 and 143 minutes C. **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied) 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 325 minutes or more **and** At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~ see page 6-~~21~~19) of between 65 and 99 minutes D. **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied) 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 150 minutes or more **and** At least 5 days of any combination of the three disciplines (O0400A4, plus O0400B4 plus O0400C4) 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~ see page 6-~~21~~19) of between 30 and 64 minutes E. **Low Intensity Criteria** (the resident qualifies if either

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			[1] or [2] is satisfied): 1. In the last 7 days: Total Therapy Minutes (calculated on page 6-~~19~~25 - 6-28) of 45 minutes or more **and** At least 3 days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4) **and** Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":** Medicare Short Stay Average Therapy Minutes (~~calculated on~~ see page 6-~~21~~19) of between 15 and 29 minutes
6	6.8	6-52 & 6-53	**Late Assessment** The SNF must complete a late assessment if the SNF fails to set the ARD within the defined ARD window for a scheduled Medicare-required assessment (including the grace days) or an OMRA when the resident is still on Part A coverage. The ARD can be no earlier than the day the omission was identified. If the ARD on the late assessment is set prior to the end of the payment period for which the Medicare-required assessment would have been effective,~~for the Medicare-required assessment that was missed,~~ the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the HIPPS rate code established by the late assessment. For example, a Medicare-required 30-day assessment with an ARD of Day 41 would be paid the default rate for Days 31 through 40 and at the HIPPS classification from the assessment beginning on Day 41. If the ARD of the late assessment is set after the end of the payment period for which the Medicare-required assessment would have been effective ~~that was missed~~ and the resident is still on Part A, the provider must still complete an assessment. The ARD can be no earlier than the day the omission was identified. The SNF must bill all covered days for that payment period at the default rate regardless of the HIPPS code calculated from the late assessment. For

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			example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace the next regularly scheduled Medicare-required assessment. The SNF would then need to complete the 30-day Medicare-required assessment that covers Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services. **Missed Assessment** If the SNF fails to set the ARD prior to the end of the last day of the ARD window, including grace days, and the resident is no longer a SNF Part A resident, 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 performed.