

CHAPTER 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

6.1 Background

The Balanced Budget Act of 1997 included the implementation of a Medicare Prospective Payment System (PPS) for skilled nursing facilities (SNFs) and hospitals with a swing bed agreement, consolidated billing, and a number of related changes. The PPS system replaced the retrospective cost-based system for SNFs under Part A of the program (**Federal Register** Vol. 63, No. 91, May 12, 1998, Final Rule). Effective with cost reporting periods beginning on or after July 1, 2002, SNF-level services furnished in rural swing bed Hospitals are paid based on the SNF PPS instead of the previous, cost-related method (**Federal Register** Vol. 66, No. 147, July 31, 2001, Final Rule). However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 included an exemption of critical access hospital swing beds from the SNF PPS.

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970s that focus on the areas of nursing home payment and quality. In addition, it is based on a foundation of knowledge and work by a number of States that developed and implemented similar case mix payment methodologies for their Medicaid nursing home payment systems.

The current focus in the development of State and Federal payment systems for nursing home care is based on recognizing the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case mix system. Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels should be higher than for those residents with less intensive care needs. In a case mix adjusted payment system, the amount of reimbursement to the nursing home is based on the resource intensity of the resident as measured by items on the Minimum Data Set (MDS). Case mix reimbursement has become a widely adopted method for financing nursing home care. The case mix approach serves as the basis for the PPS for skilled nursing facilities and swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing homes.

6.2 Using the MDS in the Medicare Prospective Payment System

A key component of the Medicare SNF PPS is the case mix reimbursement methodology used to determine resident care needs. A number of nursing home case mix systems have been developed over the last 20 years. Since the early 1990s, however, the most widely adopted approach to case mix has been the Resource Utilization Groups (RUGs). This classification

system uses information from the MDS assessment to classify SNF residents into a series of groups representing the residents' relative direct care resource requirements.

In 2005, the Centers for Medicare & Medicaid Services (CMS) initiated a national nursing home staff time measurement (STM) study, the Staff Time and Resource Intensity Verification (STRIVE) Project. The STRIVE project represents the first nationwide time study for nursing homes in the United States to be conducted since 1997, and the data collected has been used to update payment systems for Medicare SNFs and Medicaid nursing facilities (NFs). Based on this analysis, CMS has developed the RUG-IV classification system that incorporates the MDS 3.0 items.

Over half of the State Medicaid programs also use the MDS for their case mix payment systems. The RUG-IV system replaced the RUG-III for Medicare starting on 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.

6.3 Resource Utilization Groups Version IV (RUG-IV)

The RUG-IV classification system has eight major classification categories: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance Problems, and Reduced Physical Function (see Table 1). The categories, except for Extensive Services, are further divided by the intensity of the resident's ADL needs. The Special Care High, Special Care Low, and Clinically Complex categories are also divided by the presence of depression. Finally, the Behavioral Symptoms and Cognitive Performance Problems and the Reduced Physical Function categories are divided by the provision of restorative nursing services.

A calculation worksheet was developed in order to provide clinical staff with a better understanding of how the RUG-IV classification system works. The worksheet translates the standard software code into plain language to assist staff in understanding the logic behind the classification system. A copy of the calculation worksheet for the RUG-IV classification system for nursing homes can be found at the end of this section.

Table 1. Eight Major RUG-IV Classification Categories

Major RUG-IV Category	Characteristics Associated With Major RUG-IV Category
Rehabilitation Plus Extensive Services	Residents satisfying all of the following three conditions: <ul style="list-style-type: none"> • Having a minimum activity of daily living (ADL) dependency score of 2 or more. • Receiving physical therapy, occupational therapy, and/or speech-language pathology services while a resident. • While a resident, receiving complex clinical care and have needs involving tracheostomy care, ventilator/respirator, and/or infection isolation.
Rehabilitation	Residents receiving physical therapy, occupational therapy, and/or speech-language pathology services while a resident.
Extensive Services	Residents satisfying the following two conditions: <ul style="list-style-type: none"> • Having a minimum ADL dependency score of 2 or more. • While a resident, receiving complex clinical care and have needs involving: tracheostomy care, ventilator/respirator, and/or infection isolation.
Special Care High	Residents satisfying the following two conditions: <ul style="list-style-type: none"> • Having a minimum ADL dependency score of 2 or more. • Receiving complex clinical care or have serious medical conditions involving any one of the following: <ul style="list-style-type: none"> — comatose, — septicemia, — diabetes with insulin injections and insulin order changes, — quadriplegia with a higher minimum ADL dependence criterion (ADL score of 5 or more), — chronic obstructive pulmonary disease (COPD) with shortness of breath when lying flat, — fever with pneumonia, vomiting, weight loss, or tube feeding meeting intake requirement, — parenteral/IV feeding, or — respiratory therapy.

(continued)

Table 1. Eight Major RUG-IV Classification Categories (continued)

Major RUG-IV Category	Characteristics Associated With Major RUG-IV Category
Special Care Low	<p>Residents satisfying the following two conditions:</p> <ul style="list-style-type: none"> • Having a minimum ADL dependency score of 2 or more. • Receiving complex clinical care or have serious medical conditions involving any of the following: <ul style="list-style-type: none"> — cerebral palsy with ADL dependency score of 5 or more, — multiple sclerosis with ADL dependency score of 5 or more, — Parkinson's disease with ADL dependency score of 5 or more, — respiratory failure and oxygen therapy while a resident, — tube feeding meeting intake requirement, — ulcer treatment with two or more ulcers including venous ulcers, arterial ulcers or Stage II pressure ulcers, — ulcer treatment with any Stage III or IV pressure ulcer, — foot infections or wounds with application of dressing, — radiation therapy while a resident, or — dialysis while a resident.
Clinically Complex	<p>Residents receiving complex clinical care or have conditions requiring skilled nursing management, interventions or treatments involving any of the following:</p> <ul style="list-style-type: none"> • pneumonia, • hemiplegia with ADL dependency score of 5 or more, • surgical wounds or open lesions with treatment, • burns, • chemotherapy while a resident, • oxygen therapy while a resident, • IV medications while a resident, or • transfusions while a resident.

(continued)

Table 1. Eight Major RUG-IV Classification Categories (continued)

Major RUG-IV Category	Characteristics Associated With Major RUG-IV Category
Behavioral Symptoms and Cognitive Performance	<p>Residents satisfying the following two conditions:</p> <ul style="list-style-type: none"> • Having a maximum ADL dependency score of 5 or less. • Having behavioral or cognitive performance symptoms, involving any of the following: <ul style="list-style-type: none"> — difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status ≤ 9), — difficulty in making self understood, short term memory, or decision making (score on the Cognitive Performance Scale ≥ 3), — hallucinations, — delusions, — physical behavioral symptoms toward others, — verbal behavioral symptoms toward others, — other behavioral symptoms, — rejection of care, or — wandering.
Reduced Physical Function	Residents whose needs are primarily for support with activities of daily living and general supervision.

6.4 Relationship between the Assessment and the Claim

The SNF PPS establishes a schedule of Medicare assessments. Each required Medicare assessment is used to support Medicare PPS reimbursement. There are scheduled PPS assessments performed around Day 5, Day 14, Day 30, Day 60, and Day 90 of a Medicare Part A stay (as defined in Chapter 2). These scheduled assessments establish per diem payment rates for associated standard payment periods. Unscheduled off-cycle assessments are performed under certain circumstances when required under the regulations (e.g., when the resident's condition changes). See Chapter 2 for greater detail on assessment types and requirements. These unscheduled assessments may impact the per diem payment rates for days within a standard payment period.

Numerous situations exist that impact the relationship between the assessment and the claim above and beyond the information provided in this chapter. It is the responsibility of the provider to ensure that claims submitted to Medicare are accurate and meet all Medicare requirements. For example, if resident's status does not meet the criteria for Medicare Part A SNF coverage, the provider is not to bill Medicare for any non-covered days. The assignment of a RUG is not an indication that the requirements for SNF Part A have been met. Once the resident no longer requires skilled services, the provider must not bill Medicare for days that are not covered. Therefore, the following information is not to be considered all inclusive and definitive. Refer to

the **Medicare Claims Processing Manual**, Chapter 6, for detailed claims processing requirements and policies.

To verify that the Medicare bill accurately reflects the assessment information, two data items derived from the MDS assessment must be included on the Medicare claim:

Assessment Reference Date (ARD)

The ARD must be reported on the Medicare claim. CMS has developed internal mechanisms to link the assessment and billing records.

Health Insurance Prospective Payment System (HIPPS) Code

Each Medicare claim contains a five-position HIPPS code for the purpose of billing Part A covered days to the Part A/Part B Medicare Administrative Contractor (A/B MAC). The HIPPS code consists of the RUG-IV code and the Assessment Indicator (AI) as described below. CMS provides standard software and logic for HIPPS code calculation.

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 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:

Rehabilitation Plus Extensive Services:

RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX

Rehabilitation:

RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB

Extensive Services:

ES3, ES2, ES1

Special Care High:

HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1

Special Care Low:

LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1

Clinically Complex:

CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1

Behavioral Symptoms and Cognitive Performance:

BB2, BB1, BA2, BA1

Reduced Physical Function:

PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1

Default:

AAA

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. The HIPPS code included on the Medicare claim depends on the specific type of assessment involved.

The RUG 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.

The provider must ensure that all Medicare assessment requirements are met. When the provider fails to meet the Medicare assessment requirements, such as when the assessment is late (as evidenced by a late ARD), the provider may be required to bill the default code. In these situations, the provider is responsible to ensure that the default code and not the RUG group validated by CMS in Items Z0100A and Z0150A is billed for the applicable number of days. See Section 6.8 of this chapter for greater detail.

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 provides 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 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.

Table 2. Assessment Indicator First Digit Table

1st Digit Values	Assessment Type (abbreviation)	Standard* Scheduled Payment Period
0	Unscheduled PPS assessment (unsched)	Not applicable
1	PPS 5-day or readmission return (5d or readm)	Day 1 through 14
2	PPS 14-day (14d)	Day 15 through 30
3	PPS 30-day (30d)	Day 31 through 60
4	PPS 60-day (60d)	Day 61 through 90
5	PPS 90-day (90d)	Day 91 through 100
6	OBRA assessment (not coded as a PPS assessment) **	Not applicable

* These are the payment periods that apply when only the scheduled Medicare-required assessments are performed. These are subject to change when unscheduled assessments used for PPS are performed, e.g., significant change in status, or when other requirements must be met.

**In some cases, such an assessment may be used for PPS if it is later determined that qualification for Part A coverage was present at the time of the assessment (see Missed Assessment, section 6.8). For these assessments A0310A will be 01 to 06 and A0310B will be 99.

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 performed as separate assessments or combined with other assessments.

A stand-alone unscheduled assessment used for PPS will not establish the payment rate for a standard payment period. Rather a stand-alone unscheduled assessment will modify the payment rate for all or part of a standard payment period, but only when the rate for that standard period has been established by a prior PPS scheduled assessment. For example, if a PPS 14-day scheduled assessment has established the payment rate for the standard Day 15 to Day 30 payment period, then an SCSA with an ARD on Day 20 will modify the payment rate from the ARD (Day 20) to the end of the payment period (Day 30).

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 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.

Different types of unscheduled assessments start modifying the payment rate on different dates.

- OBRA SCSA, OBRA SCPA, and Swing Bed CCA assessments begin modifying the payment rate on the ARD based on the Medicare RUG (Z0100A). The exception is when the ARD of the unscheduled assessment is a grace day of a scheduled PPS assessment. In that case, the Medicare RUG (Z0100A) calculated from the unscheduled assessment takes effect on the first day of the standard payment period for the scheduled assessment.
- A Start of Therapy OMRA Medicare RUG (item Z0100A) takes effect on the day therapy started.
- An End of Therapy OMRA Medicare Non-Therapy RUG (Z0150A) takes effect on the day after the last day of therapy provided.
- A Change of Therapy OMRA Medicare Therapy RUG (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 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 Indicator 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.
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 3** presents the most common situation.

- **EXAMPLE 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 provided) to the end of the current payment period of Day 30.
4. Consider Example 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 that payment period.
- **EXAMPLE 4.** The PPS 30-day assessment is performed with ARD on Day 27 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. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 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 previously ended.
5. Consider Example 5 where an End of Therapy OMRA is performed and followed within a few days by a scheduled PPS assessment.
- **EXAMPLE 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 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.
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 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.

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.

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 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 change in therapy evaluation process is discontinued.

Table 3 presents the types of unscheduled assessments, the second AI digit associated with each assessment type, and the payment impact for standard payment periods.

Table 3. Assessment Indicator Second Digit Table

Second Digit Values	Assessment Type	Impact on Standard Payment Period
0	Either a scheduled PPS assessment not replaced by or combined with an unscheduled PPS assessment OR an OBRA assessment not coded as a PPS assessment	<ul style="list-style-type: none"> • No impact on the standard payment period (the assessment is not unscheduled). • If the second digit value is 0, then the first digit must be 1 through 6, indicating a scheduled PPS assessment or an OBRA assessment not coded as a PPS assessment. • If the first digit value is a 6, then the second digit value must be 0.

(continued)

Table 3. Assessment Indicator Second Digit Table (continued)

Second Digit Values	Assessment Type	Impact on Standard Payment Period
1	<p>Either an unscheduled OBRA assessment or Swing Bed CCA Do NOT use if</p> <ul style="list-style-type: none"> • Combined with any OMRA • Medicare Short Stay assessment 	<ul style="list-style-type: none"> • If the ARD of the unscheduled assessment is not within the ARD window of any scheduled PPS assessment, including grace days (the first digit is 0): <ul style="list-style-type: none"> — Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period. • If the ARD of the unscheduled assessment is within the ARD window of a scheduled PPS assessment, not using grace days: <ul style="list-style-type: none"> — Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period. • If the ARD of the unscheduled assessment is a grace day of a scheduled PPS assessment: <ul style="list-style-type: none"> — Use the Medicare RUG (Z0100A) from the start of the standard payment period.
2	<p>Start of Therapy OMRA Do NOT use if</p> <ul style="list-style-type: none"> • Medicare Short Stay assessment • Combined with End of Therapy OMRA • Combined with unscheduled OBRA • Combined with Swing Bed CCA 	<ul style="list-style-type: none"> • If the unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A): <ul style="list-style-type: none"> — Use the Medicare RUG (Z0100A) from the unscheduled assessment's earliest start of therapy date (speech-language pathology services in O0400A5, occupational therapy in O0400B5, or physical therapy in O0400C5) through the end of standard payment period. • If the unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of standard payment period. This is not a valid assessment and it will not be accepted by CMS.
3	<p>Start of Therapy OMRA combined with either an unscheduled OBRA assessment or a Swing Bed CCA Do NOT use if</p> <ul style="list-style-type: none"> • Medicare Short Stay assessment • Combined with End of Therapy OMRA 	<ul style="list-style-type: none"> • If unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A): <ul style="list-style-type: none"> — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the end of 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.

(continued)

Table 3. Assessment Indicator Second Digit Table (continued)

Second Digit Values	Assessment Type	Impact on Standard Payment Period
4	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 <ul style="list-style-type: none"> • Combined with Start of Therapy OMRA • Medicare Short Stay assessment • End of Therapy OMRA reporting Resumption of Therapy (EOT-R) 	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 end of current payment period.
5	Start of Therapy OMRA combined with End of Therapy OMRA not reporting Resumption of Therapy Do NOT use if <ul style="list-style-type: none"> • Medicare Short Stay assessment • Combined with unscheduled OBRA • Combined with Swing Bed CCA • End of Therapy OMRA reporting Resumption of Therapy (EOT-R) 	<ul style="list-style-type: none"> • If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> — 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 end of current 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.
6	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 <ol style="list-style-type: none"> 1. Medicare Short Stay assessment 2. End of Therapy OMRA reporting Resumption of Therapy (EOT-R) 	<ul style="list-style-type: none"> • If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> — 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 end of current 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.
7	Medicare Short Stay Assessment (see Medicare Short Stay Assessment below for the definition of this assessment.)	See Medicare Short Stay Assessment below for impact on payment periods.

(continued)

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 <ul style="list-style-type: none"> Combined with Start of Therapy OMRA Medicare Short Stay assessment 	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Medicare Short Stay assessment Combined with unscheduled OBRA Combined with Swing Bed CCA 	<ul style="list-style-type: none"> If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Medicare Short Stay assessment 	<ul style="list-style-type: none"> If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> 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.

(continued)

Table 3. Assessment Indicator Second Digit Table (continued)

Second Digit Values	Assessment Type	Impact on Standard Payment Period
D	Change of Therapy OMRA; whether or not combined with unscheduled OBRA assessment and whether or not combined with Swing Bed CCA	<ul style="list-style-type: none"> 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.

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 and Chapter 2 of this manual for details.

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.

Additional AI Codes

There are also two additional AI Codes (shown in Table 6-4) when a Medicare SNF Part A claim is filed without a corresponding PPS assessment having been completed or the assessment has invalid reasons for assessment.

Table 4. Additional Assessment Indicator Codes

Additional Assessment Indicator (AI) Codes	Description
00	This is the AI required when billing the default RUG code of AAA for a missed assessment only when specific circumstances are met (see Section 6.8 of this chapter for greater detail). The default code is paid based upon the payment associated with the lowest resource utilization group (RUG), PA1.
X	The AI "error" code provided by the RUG-IV grouper when RUG-IV cannot be calculated for the type of record (e.g., the record is an entry record). This is not an appropriate billing code.

Medicare Short Stay Assessment

To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, the assessment must be a Start of Therapy OMRA, the resident must have been discharged from Part A on or before day 8 of the Part A stay, and the resident must have completed only 1 to 4 days of therapy, with therapy having started during the last 4 days of the Part A stay. To be considered a Medicare Short Stay assessment and use the

special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (A0310C = 1).** This assessment may be 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 performed.** The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.
3. **The ARD (A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.
4. **The ARD (A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.
5. **The ARD (A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Item O0400A5, O0400B5, or O0400C5, whichever is earliest).** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare Part A covered stay (including weekends).** The end of Medicare stay date (A2400C) minus the earliest start date for the three therapy disciplines (O0400A5, O0400B5, or O0400C5) must be 3 days or less.
7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (A2400C). Therapy is considered to be ongoing when:
 - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
 - The resident's SNF benefit exhausted and therapy continued to be provided, or
 - The resident's payer source changed and therapy continued to be provided.
8. **The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Z0100A).** If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.

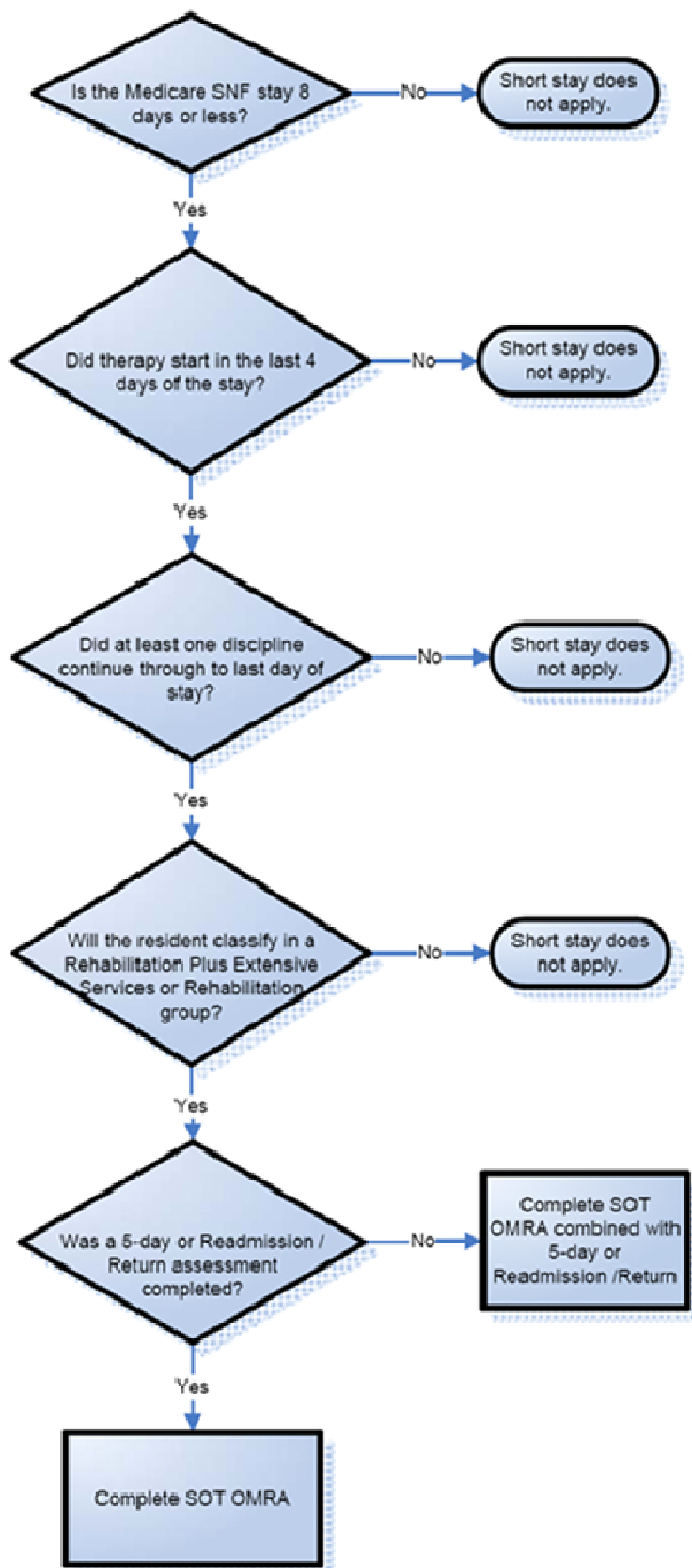
See below for Medicare Short Stay Assessment Algorithm.

If all eight of these conditions are met, then MDS Item Z0100C (Medicare Short Stay Assessment indicator) is coded “Yes.” the assignment of the RUG-IV rehabilitation therapy classification is calculated based on average daily minutes actually provided (when there is a fraction, the total therapy minutes is not rounded and only the whole number is used), and the resulting RUG-IV group is recorded in MDS Item Z0100A (Medicare Part A HIPPS Code).

1. 15-29 average daily therapy minutes ► Rehabilitation Low category (RLx)
2. 30-64 average daily therapy minutes ► Rehabilitation Medium category (RMx)
3. 65-99 average daily therapy minutes ► Rehabilitation High category (RHx)
4. 100-143 average daily therapy minutes ► Rehabilitation Very High category (RVx)
5. 144 or greater average daily therapy minutes ► Rehabilitation Ultra High category (RUx)

See the RUG-IV Calculation Worksheet in Section 6.6 for details of the rehabilitation classification for a Medicare Short Stay Assessment.

Medicare Short Stay Assessment Algorithm



Medicare Short Stay Assessment Requirements:

All 8 must be true

Assessment Requirements:

1. Must be SOT OMRA
2. 5-day or readmission/return assessment must be completed (may be combined with the SOT OMRA)

ARD Requirements:

3. Must be Day 8 or earlier of Part A stay
4. Must be last day of Part A stay (see Item 2400 instructions)
5. Must be no more than 3 days after the start of therapy

Rehabilitation Requirements:

6. Must have started in last 4 days of Part A stay
7. Must continue through last day of Part A stay

RUG Requirement:

8. Must classify resident into a Rehabilitation Plus Extensive Services or Rehabilitation group

Note: When the earliest start of therapy is 1st day of stay, then the Part A stay must be 4 days or less

The impacts on the payment periods for the Medicare Short Stay assessment are as follows:

1. If the earliest start of therapy date (Items O0400A5, O0400B5, or O0400C5) is the first day of the short stay, use the Medicare Short Stay assessment Medicare Part A RUG (Z0100) from the beginning of the short stay through the end of the stay (the Medicare stay must be 4 days or less).
2. If the earliest start of therapy date is after the first day of the short stay, the following apply:
 - a. If a 5-day or readmission/return assessment was completed prior to Medicare Short Stay assessment, use the Medicare Part A RUG (Z0100A) from that assessment for the first day of the short stay through the day before therapy started; then use the Medicare Part A RUG (Z0100A) from the Medicare Short Stay assessment from the day therapy started through the end of the short stay; or
 - b. If the Start of Therapy OMRA is combined with a 5-day or readmission/return assessment, use the Medicare Part A non-therapy RUG (Z0150A) for the first day of the short stay through the day before therapy started; then use the Medicare Part A RUG (Z0100A) from the day therapy started through the end of the short stay.

6.5 SNF PPS Eligibility Criteria

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized in this section. Refer to the **Medicare General Information, Eligibility, and Entitlement Manual**, Chapter 1 (Pub. 100-1), and the **Medicare Benefit Policy Manual**, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

Technical Eligibility Requirements

The beneficiary must meet the following criteria:

- Beneficiary is Enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay (i.e., three midnights).
- Admission for SNF-level services is within 30 days of discharge from an acute care stay or within 30 days of discharge from a SNF level of care.

Clinical Eligibility Requirements

A beneficiary is eligible for SNF extended care if all of the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition:

- for which the resident was treated during the qualifying hospital stay, or
- that arose while the resident was in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

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.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20). The initial certification
 - affirms, per the required content found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, or
 - validates via written statement that the beneficiary's assignment to one of the upper RUG-IV (Top 52) groups is correct.
- **Re-certifications** are used to document the continued need for skilled extended care services.
 - The first re-certification is required no later than the 14th day.
 - Subsequent re-certifications are required at no later than 30 days intervals after the date of the first re-certification.
 - The initial certification and first re-certification may be signed at the same time.

6.6 RUG-IV 66-Group Model Calculation Worksheet for SNFs

The purpose of this RUG-IV Version 1.00 calculation worksheet for the 66-group model is to provide a step-by-step walk-through to manually determine the appropriate RUG-IV Classification based on the data from an MDS assessment. The worksheet takes the grouper logic and puts it into words. We have carefully reviewed the worksheet to ensure that it represents the standard logic.

In the RUG-IV 66-group model, there are 23 different Rehabilitation Plus Extensive Services and Rehabilitation groups, representing 10 different levels of rehabilitation services. In the 66-group model, the residents in the Rehabilitation Plus Extensive Services groups have the highest level of combined nursing and rehabilitation need, while residents in the Rehabilitation groups have the next highest level of need. Therefore, the 66-group model has the Rehabilitation Plus Extensive Services groups first followed by the Rehabilitation groups, the Extensive Services groups, the Special Care High groups, the Special Care Low groups, the Clinically Complex groups, the Behavioral Symptoms and Cognitive Performance groups, and the Reduced Physical Function groups.

There are two basic approaches to RUG-IV Classification: (1) hierarchical classification and (2) index maximizing classification. The current worksheet was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are

included below (see “Index Maximizing Classification”). Note that the RUG classification used for Medicare PPS Part A billing is based on the index maximizing approach.

Hierarchical Classification. The present worksheet employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, start at the top and work down through the RUG-IV model; the assigned classification is the first group for which the resident qualifies. In other words, start with the Rehabilitation Plus Extensive Services groups at the top of the RUG-IV model. Then go down through the groups in hierarchical order: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. When you find the first of the 66 individual RUG-IV groups for which the resident qualifies, assign that group as the RUG-IV classification.

If the resident qualifies in the Extensive Services group and a Special Care High group, always choose the Extensive Services classification because it is higher in the hierarchy. Likewise, if the resident qualifies for Special Care Low and Clinically Complex, always choose Special Care Low. In hierarchical classification, always pick the group nearest the top of the model.

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 for the appropriate Federal Fiscal Year.

While the following worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. For index maximizing, evaluate all classification groups rather than assigning the resident to the first qualifying group. In the index maximizing approach, again start at the beginning of the worksheet. Then work down through all of the 66 RUG-IV Classification groups, ignoring instructions to skip groups and noting each group for which the resident qualifies. When finished, record the CMI for each of these groups. Select the group with the highest CMI. This group is the index-maximized classification for the resident.

Non-Therapy Classification. In some instances, the SNF provider may be required to report, on the SNF Medicare claim, a non-therapy RUG-IV classification according to the SNF PPS policies (as noted elsewhere in this chapter, Chapter 8 of the **Medicare Benefit Policy Manual**, and Chapter 6 of the **Medicare Claims Processing Manual**). The non-therapy classification uses all the RUG-IV payment items except the rehabilitation therapy Items (O0400A,B,C) to determine a non-therapy, clinical RUG. To obtain a non-therapy RUG with this worksheet, skip Category I (Rehabilitation Plus Extensive Services) and Category II (Rehabilitation) and start with Category III (Extensive Services). Both the standard Medicare Part A RUG reported in Item Z0100A and the Medicare Part A non-therapy RUG in Item Z0150A are recorded on the MDS 3.0. When rehabilitation services are not provided, the standard Medicare Part A RUG will match the Medicare Part A non-therapy RUG.

CALCULATION OF TOTAL “ADL” SCORE

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The ADL score is a component of the calculation for placement in all RUG-IV groups. The ADL score is based upon the four “late loss” ADLs (bed mobility, transfer, toilet use, and eating), and this score indicates the level of functional assistance or support required by the resident. It is a very important component of the classification process.

STEP # 1

To calculate the ADL score use the following chart for bed mobility (G0110A), transfer (G0110B), and toilet use (G0110I). **Enter the ADL score for each item.**

Self- Performance Column 1 =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 7, or 8	and	(any number)	0	G0110A = ____
2	and	(any number)	1	G0110B = ____
3	and	-, 0, 1, or 2	2	G0110I = ____
4	and	-, 0, 1, or 2	3	
3 or 4	and	3	4	

STEP # 2

To calculate the ADL score for eating (G0110H), use the following chart. Enter ADL score.

Self-Performance Column 1 (G0110H) =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 2, 7, or 8	and	-, 0, 1, or 8	0	G0110H = ____
-, 0, 1, 2, 7, or 8	and	2 or 3	2	
3 or 4	and	-, 0, or 1	2	
3	and	2 or 3	3	
4	and	2 or 3	4	

STEP # 3

Add the four scores for the total ADL score. This is the **RUG-IV TOTAL ADL SCORE**. The total ADL score ranges from 0 through 16.

TOTAL RUG-IV ADL SCORE _____

Other ADLs are also very important, but the research indicates that the late loss ADLs predict resource use most accurately. The early loss ADLs do not significantly change the classification hierarchy or add to the prediction of resource use.

CALCULATION OF TOTAL REHABILITATION THERAPY MINUTES

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

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. 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 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.

Skip this section if therapy is not provided.

In Steps #1 through #3 in calculating Rehabilitation Therapy Minutes, retain all decimal places in the calculated values. Values where decimal points are retained are indicated by an asterisk ().*

STEP # 1

Calculate the total minutes for speech-language pathology services as follows:

Add the individual minutes (O0400A1) and one-half of the concurrent minutes (O0400A2). If classification is for Medicare for FY2011 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.

Total Minutes* = _____

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.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Speech-Language Pathology Services Minutes* = _____

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-quarter of the group minutes and record as Total Minutes. Total Minutes* = _____

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.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Occupational Therapy Minutes* = _____

STEP # 3

Calculate the total minutes for physical therapy as follows:

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.

Total Minutes* = _____

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 (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.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Physical Therapy Minutes* = _____

STEP # 4

Sum the speech-language pathology services minutes, occupational therapy minutes, and physical therapy minutes and record as Total Therapy Minutes. These are the minutes that will be used for RUG-IV rehabilitation therapy classification (when there is a fraction, the total therapy minutes is not rounded and only the whole number is used).

TOTAL THERAPY MINUTES[^] = _____

[^]Total Therapy Minutes is not rounded. Record only the whole number with all values after the decimal dropped.

Total Rehabilitation Therapy Minutes Calculation Example

Mrs. D., whose stay is covered under SNF PPS, received the following rehabilitation services during FY2012 (group therapy time is allocated) as follows:

Speech-language Pathology Services:

Individual minutes = 110 (Item O0400A1),

Concurrent minutes = 99 (Item O0400A2),

Group minutes = 100 (Item O0400A3).

Calculate total SLP minutes = $110 + 99/2 + 100/4 = 184.5$ (retain the decimal).

Check group proportion (after group allocation) = $(100/4)/184.5 = 0.136$.

Do not adjust SLP minutes for Medicare Part A since group proportion is not greater than .25. Use unadjusted total SLP minutes.

Total Speech-Language Pathology Services Minutes = 184.5 (retain the decimal).

Occupational Therapy:

Individual minutes = 78 (Item O0400B1),

Concurrent minutes = 79 (Item O0400B2),

Group minutes = 320 (Item O0400B3).

Calculate total OT minutes = $78 + 79/2 + 320/4 = 197.5$ (retain the decimal).

Check group proportion = $(320/4)/197.5 = 0.405$.

Adjust OT minutes for Medicare Part A since group proportion is greater than .25.

Adjusted Occupational Therapy Minutes = $[(78 + 79/2) \times 4]/3 = 156.6666$ (retain the decimal).

Physical Therapy:

Individual minutes = 92 (Item O0400C1),

Concurrent minutes = 93 (Item O0400C2),

Group minutes = 376 (Item O0400C3).

Calculate total PT minutes = $92 + 93/2 + 376/4 = 232.5$ (retain the decimal).

Check group proportion = $(376/4)/232.5 = 0.404$.

Adjust PT minutes for Medicare Part A since group proportion is greater than .25.

Adjusted Physical Therapy Minutes = $[(92 + 93/2) \times 4]/3 = 184.6666$ (retain the decimal).

Total Adjusted Therapy Minutes:

Sum SLP, OT and PT minutes after any adjustment= $184.5 + 156.6666 + 184.6666 = 525.8332$

Drop decimals = **525 minutes**

(this is the total therapy minutes value for RUG-IV classification).

MEDICARE SHORT STAY ASSESSMENT

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

STEP # 1

Set the Medicare Short Stay Indicator (Z0100C) as follows:

RUG-IV uses an alternative rehabilitation therapy classification when an assessment is a Medicare Short Stay assessment. To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (Item A0310C = 1).** This assessment may be 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 performed.** The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.
3. **The ARD (Item A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare covered stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.
4. **The ARD (Item A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.
5. **The ARD (Item A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Items O0400A5, O0400B5, or O0400C5, whichever is earliest).** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short Stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare Part A stay (including weekends).** The end of Medicare stay date (Item A2400C) minus the earliest start date for the three therapy disciplines (Items O0400A5, O0400B5, or O0400C5) must be 3 days or less.
7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (Items O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (Item A2400C). Therapy is considered to be ongoing when:
 - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
 - The resident's SNF benefit exhausted and therapy continued to be provided, or
 - The resident's payer source changed and therapy continued to be provided.

8. **The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Item Z0100A).** If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.

If all eight conditions are satisfied, record "Yes" in the Medicare Short Stay Assessment Indicator Z0100C); otherwise record "No."

MEDICARE SHORT STAY ASSESMENT INDICATOR Yes_____ No_____

STEP # 2

If the Medicare Short Stay Assessment Indicator is "Yes," then calculate the Medicare Short Stay Average Therapy Minutes as follows:

This average is the Total Therapy Minutes (calculated above in Calculation of Total Rehabilitation Therapy Minutes) divided by the number of days from the start of therapy (earliest date in O0400A5, O0400B5, and O0400C5) through the assessment reference date (A2300). For example, if therapy started on August 1 and the assessment reference date is August 3, the average minutes is calculated by dividing by 3 days. Discard all numbers after the decimal point and record the result.

MEDICARE SHORT STAY AVERAGE THERAPY MINUTES = _____

See Section 6.4 for Medicare Short Stay Assessment Algorithm.

CATEGORY I: REHABILITATION PLUS EXTENSIVE SERVICES

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

Start the classification process beginning with the Rehabilitation Plus Extensive Services category. In order for a resident to qualify for this category, he/she must meet three requirements: (1) have an ADL score of 2 or more, (2) meet one of the criteria for the Extensive Services category, and (3) meet the criteria for one of the Rehabilitation categories.

STEP # 1

Check the resident's ADL score. If the resident's ADL score is 2 or higher, **go to Step #2.**

If the ADL score is less than 2, skip to Category II now.

STEP # 2

Determine whether the resident is coded for **one** of the following treatments or services:

O0100E2	Tracheostomy care while a resident
O0100F2	Ventilator or respirator while a resident
O0100M2	Infection isolation while a resident

If the resident does not receive one of these treatments or services, skip to Category II now.

STEP # 3

Determine if the resident's rehabilitation therapy services (speech-language pathology services, or occupational or physical therapy) satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for a Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

- **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the past 7 days:
 - Total Therapy Minutes (calculated on page 6-19) 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 page 6-21) of 144 minutes or more

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RUX
2-10	RUL

- **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) 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 page 6-21) of between 100 and 143 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RVX
2-10	RVL

- **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) 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 page 6-21) of between 65 and 99 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RHX
2-10	RHL

- **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) 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 page 6-21) of between 30 and 64 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RMX
2-10	RML

- **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) 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 page 6-21) of between 15 and 29 minutes
- *Restorative Nursing Services
- H0200C, H0500** Urinary toileting program and/or bowel toileting program
 - O0500A,B** Passive and/or active ROM
 - O0500C Splint or brace assistance
 - O0500D,F** Bed mobility and/or walking training
 - O0500E Transfer training
 - O0500G Dressing and/or grooming training
 - O0500H Eating and/or swallowing training
 - O0500I Amputation/prostheses care
 - O0500J Communication training
- **Count as one service even if both provided

RUG-IV ADL Score

2-16

RUG-IV Class

RLX

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Plus Extensive Services Category, proceed to Category II.

CATEGORY II: REHABILITATION

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

Rehabilitation therapy is any combination of the disciplines of physical therapy, occupational therapy, or speech-language pathology services, and is located in Section O (Items at O0400A,B,C). Nursing rehabilitation is also considered for the low intensity classification level. It consists of urinary or bowel toileting program, providing active or passive range of motion, providing splint/brace assistance, training in bed mobility or walking, training in transfer, training in dressing/grooming, training in eating/swallowing, training in amputation/prosthesis care, and training in communication. This information is found in Sections H0200C, H0500, and O0500.

STEP # 1

Determine whether the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for one Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

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) 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 page 6-21) of 144 minutes or more

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RUC
6-10	RUB
0-5	RUA

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) 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 page 6-21) of between 100 and 143 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RVC
6-10	RVB
0-5	RVA

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) 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 page 6-21) of between 65 and 99 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RHC
6-10	RHB
0-5	RHA

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) 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 page 6-21) of between 30 and 64 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RMC
6-10	RMB
0-5	RMA

E. 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) 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 page 6-21) of between 15 and 29 minutes

*Nursing Restorative Services

H0200C, H0500** Urinary toileting program and/or bowel toileting program

O0500A,B** Passive and/or active ROM

O0500C Splint or brace assistance

O0500D,F** Bed mobility and/or walking training

O0500E Transfer training

O0500G Dressing and/or grooming training

O0500H Eating and/or swallowing training

O0500I Amputation/prostheses care

O0500J Communication training

**Count as one service even if both provided

RUG-IV ADL Score

11-16

0-10

RUG-IV Class

RLB

RLA

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Category, proceed to Category III.

CATEGORY III: EXTENSIVE SERVICES

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on various services provided. Use the following instructions to begin the calculation:

STEP # 1

Determine whether the resident is coded for **one** of the following treatments or services:

O0100E2	Tracheostomy care while a resident
O0100F2	Ventilator or respirator while a resident
O0100M2	Infection isolation while a resident

If the resident does not receive one of these treatments or services, skip to Category IV now.

STEP # 2

If at least **one** of these treatments or services is coded and the resident has a total RUG-IV ADL score of 2 or more, he/she classifies as Extensive Services. **Move to Step #3. If the resident's ADL score is 0 or 1, s/he classifies as Clinically Complex. Skip to Category VI, Step #2.**

STEP # 3

The resident classifies in the Extensive Services category according to the following chart:

<u>Extensive Service Conditions</u>	<u>RUG-IV Class</u>
Tracheostomy care* and ventilator/respirator*	ES3
Tracheostomy care* or ventilator/respirator*	ES2
Infection isolation*	ES1
without tracheostomy care*	
without ventilator/respirator*	

*while a resident

RUG-IV Classification _____

If the resident does not classify in the Extensive Services Category, proceed to Category IV.

CATEGORY IV: SPECIAL CARE HIGH

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

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

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, ADLs	Comatose and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, and G0110I1 all equal 4 or 8)
I2100	Septicemia
I2900, N0350A,B	Diabetes with both of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, ADL Score	Quadriplegia with ADL score ≥ 5
I6200, J1100C	Chronic obstructive pulmonary disease and shortness of breath when lying flat
J1550A, others	Fever and one of the following; I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0500B Feeding tube*
K0500A	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:

- (1) K0700A is 51% or more of total calories OR
- (2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to Category V now.

STEP # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care High. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

STEP # 3

Evaluate for 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 Resident Mood Interview (PHQ-9[®]) or the Staff Assessment of Resident Mood (PHQ-9-OV[®]). Instructions for completing the PHQ-9[®] are in Chapter 3, Section D. The following items comprise the PHQ-9[®]:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP # 4

Select the Special Care High classification based on the ADL score and the presence or absence of depression record this classification:

<u>RUG-IV ADL Score</u>	<u>Depressed</u>	<u>RUG-IV Class</u>
15-16	Yes	HE2
15-16	No	HE1
11-14	Yes	HD2
11-14	No	HD1
6-10	Yes	HC2
6-10	No	HC1
2-5	Yes	HB2
2-5	No	HB1

RUG-IV CLASSIFICATION _____

CATEGORY V: SPECIAL CARE LOW

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

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

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

I4400, ADL Score	Cerebral palsy, with ADL score ≥ 5
I5200, ADL Score	Multiple sclerosis, with ADL score ≥ 5
I5300, ADL Score	Parkinson's disease, with ADL score ≥ 5
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0500B	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1,D1,F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A,B,C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:

- (1) K0700A is 51% or more of total calories OR
- (2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:

- M1200A,B# Pressure relieving chair and/or bed
- M1200C Turning/repositioning
- M1200D Nutrition or hydration intervention
- M1200E Ulcer care
- M1200G Application of dressings (not to feet)
- M1200H Application of ointments (not to feet)

#Count as one treatment even if both provided

If the resident does not have one of these conditions, skip to Category VI now.

STEP # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care Low. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

STEP # 3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9[®]) or the Staff Assessment of Resident Mood (PHQ-9-OV[®]). Instructions for completing the PHQ-9[®] are in Chapter 3, Section D. The following items comprise the PHQ-9[®]:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP # 4

Select the Special Care Low classification based on the ADL score and the presence or absence of depression; record this classification:

<u>RUG-IV ADL Score</u>	<u>Depressed</u>	<u>RUG-IV Class</u>
15-16	Yes	LE2
15-16	No	LE1
11-14	Yes	LD2
11-14	No	LD1
6-10	Yes	LC2
6-10	No	LC1
2-5	Yes	LB2
2-5	No	LB1

RUG-IV CLASSIFICATION _____

CATEGORY VI: CLINICALLY COMPLEX

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

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

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

I2000	Pneumonia
I4900, ADL Score	Hemiplegia/hemiparesis with ADL score ≥ 5
M1040D,E	Surgical wounds or open lesions with any selected skin treatment*
M1040F	Burns
O0100A2	Chemotherapy while a resident
O0100C2	Oxygen therapy while a resident
O0100H2	IV medications while a resident
O0100I2	Transfusions while a resident

*Selected Skin Treatments

M1200F Surgical wound care

M1200G Application of dressing (not to feet)

M1200H Application of ointments (not to feet)

If the resident does not have one of these conditions, skip to Category VII now.

STEP # 2

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9[©]) or the Staff Assessment of Resident Mood (PHQ-9-OV[©]). Instructions for completing the PHQ-9[©] are in Chapter 3, section D. The following items comprise the PHQ-9[©]:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. A higher Total Severity Score is associated with more symptoms of depression. For the resident interview, a Total Severity Score of 99 indicates that the interview was not successful.

The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP # 3

Select the Clinically Complex classification based on the ADL score and the presence or absence of depression record this classification:

<u>RUG-IV ADL Score</u>	<u>Depressed</u>	<u>RUG-IV Class</u>
15-16	YES	CE2
15-16	NO	CE1
11-14	YES	CD2
11-14	NO	CD1
6-10	YES	CC2
6-10	NO	CC1
2-5	YES	CB2
2-5	NO	CB1
0-1	YES	CA2
0-1	NO	CA1

RUG-IV CLASSIFICATION _____

CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

Classification in this category is based on the presence of certain behavioral symptoms or the resident's cognitive performance. Use the following instructions:

STEP # 1

Determine the resident's ADL score. If the resident's ADL score is 5 or less, go to Step #2.

If the ADL score is greater than 5, skip to Category VIII now.

STEP # 2

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for Item C0100), skip the remainder of this step and proceed to Step #3 to check staff assessment for cognitive impairment.

Determine the resident's cognitive status based on resident interview using the BIMS. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS items involve the following:

C0200	Repetition of three words
C0300	Temporal orientation
C0400	Recall

Item C0500 provides a BIMS Summary Score for these items and indicates the resident's cognitive performance, with a score of 15 indicating the best cognitive performance and 0 indicating the worst performance. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

Determine whether the resident is cognitively impaired. **If the resident's Summary Score is less than or equal to 9, he or she is cognitively impaired and classifies in the Behavioral Symptoms and Cognitive Performance category. Skip to Step #5.**

If the resident's summary score is greater than 9 but not 99, proceed to Step #4 to check behavioral symptoms.

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), proceed to Step #3 to check staff assessment for cognitive impairment.

STEP # 3

Determine whether the resident is cognitively impaired based on the staff assessment rather than on resident interview. The RUG-IV Cognitive Performance Scale (CPS) is used to determine cognitive impairment.

The resident is cognitively impaired if **one** of the three following conditions exists:

1. B0100 Coma (B0100 = 1) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0100I1 all = 4 or 8)
2. C1000 Severely impaired cognitive skills (C1000 = 3)
3. B0700, C0700, C1000 Two or more of the following impairment indicators are present:
 - B0700 > 0 Problem being understood
 - C0700 = 1 Short-term memory problem
 - C1000 > 0 Cognitive skills problem

and

One or more of the following severe impairment indicators are present:

 - B0700 >= 2 Severe problem being understood
 - C1000 >= 2 Severe cognitive skills problem

If the resident meets the criteria for being cognitively impaired, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Skip to Step #5. If he or she does not present with a cognitive impairment as defined here, proceed to Step #4.

STEP # 4

Determine whether the resident presents with **one** of the following behavioral symptoms:

- | | |
|--------|---|
| E0100A | Hallucinations |
| E0100B | Delusions |
| E0200A | Physical behavioral symptoms directed toward others (2 or 3) |
| E0200B | Verbal behavioral symptoms directed toward others (2 or 3) |
| E0200C | Other behavioral symptoms not directed toward others (2 or 3) |
| E0800 | Rejection of care (2 or 3) |
| E0900 | Wandering (2 or 3) |

If the resident presents with one of the symptoms above, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Proceed to Step #5. If he or she does not present with behavioral symptoms or a cognitive impairment, skip to Category VIII.

STEP # 5**Determine Restorative Nursing Count**

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

STEP # 6

Select the final RUG-IV Classification by using the total RUG-IV ADL score and the Restorative Nursing Count.

<u>RUG-IV ADL Score</u>	<u>Restorative Nursing</u>	<u>RUG-IV Class</u>
2-5	2 or more	BB2
2-5	0 or 1	BB1
0-1	2 or more	BA2
0-1	0 or 1	BA1

RUG-IV CLASSIFICATION _____

CATEGORY VIII: REDUCED PHYSICAL FUNCTION

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

STEP # 1

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a RUG-IV ADL score greater than 5, are placed in this category.

STEP # 2

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

STEP # 3

Select the RUG-IV Classification by using the RUG-IV ADL score and the Restorative Nursing Count.

<u>RUG-IV ADL Score</u>	<u>Restorative Nursing</u>	<u>RUG-IV Class</u>
15-16	2 or more	PE2
15-16	0 or 1	PE1
11-14	2 or more	PD2
11-14	0 or 1	PD1
6-10	2 or more	PC2
6-10	0 or 1	PC1
2-5	2 or more	PB2
2-5	0 or 1	PB1
0-1	2 or more	PA2
0-1	0 or 1	PA1

RUG-IV CLASSIFICATION _____

ADJUSTMENT FOR START OF THERAPY OMRA

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

A Start of Therapy (SOT) OMRA is a Medicare assessment used to initiate a Medicare payment level in either a Rehabilitation Plus Extensive or Rehabilitation group after rehabilitation therapy starts. The SOT OMRA is an abbreviated assessment that does not contain all of the items used for RUG-IV classification. The SOT OMRA only contains the RUG-IV items necessary for a Rehabilitation Plus Extensive or Rehabilitation classification. Classifications below the Rehabilitation category cannot be determined from an SOT OMRA unless it is combined with an assessment that contains all of the RUG-IV items (i.e., an OBRA assessment or other type of PPS assessment).

MEDICARE ADJUSTMENTS

Adjustments are performed for Medicare classification (Item Z0100A) on an SOT OMRA. There are three different situations relevant to Medicare classification adjustments as follows:

Situation 1

If an assessment is an SOT OMRA, indicated by MDS Item A0310C = 1 or 3, whether or not it is combined with other types of assessments, then the Medicare Index Maximized RUG-IV classification in item Z0100A must be a Rehabilitation Plus Extensive Services group or a Rehabilitation group. Lower classifications are not valid for Z0100A on an SOT OMRA.

If the Z0100A classification for any SOT OMRA (Item A0310C = 1 or 3) *is not* in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then the following adjustment should be made:

1. The Medicare RUG-IV group reported in Item Z0100A should be *adjusted to AAA* (the default group), the assessment should be 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.

Situation 2

If the Z0100A classification for an SOT OMRA (Item A0310C = 1), *not combined* with an OBRA assessment or other PPS assessment, *is* in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then the following adjustment applies:

1. The Medicare Non-Therapy RUG-IV group reported in Item Z0150A should be *adjusted to AAA* (the default group).

Situation 3

If the Z0100A classification for an SOT OMRA, *combined* with an OBRA assessment or other PPS assessment, *is* in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then *no adjustment* is necessary.

OTHER PAYER ADJUSTMENT

This other payer adjustment is applied when performing the Medicaid RUG-IV classification for Items Z0200A and Z0250A or for classification for other payers.

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).

6.7 SNF PPS Policies

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.

Delay in Requiring and Receiving Skilled Services (30-Day Transfer)

There are instances in which the beneficiary does not require SNF level of care services when initially admitted to the SNF. When the beneficiary requires and receives SNF level of care services within 30 days from the hospital discharge, Day 1 for the Medicare assessment schedule is the day on which SNF level of care services begins. For example, if a beneficiary is discharged from the hospital on August 1 and the SNF determines on August 31 that the beneficiary requires skilled service for a condition that was treated during the qualifying hospital stay, then the SNF would start the Medicare assessment schedule with a 5-day Medicare-required assessment, with August 31 as Day 1 for scheduling purposes. However, if the beneficiary requires and receives a SNF level of care 31 or more days after the hospital discharge, the beneficiary does not qualify for a SNF Part A stay (see Medical Appropriateness Exception below).

Medical Appropriateness Exception (Deferred Treatment)

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 performed. Day 1 of the stay will be the first day on which the resident starts therapy services.

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services

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:

1. Less than 30 days have elapsed since the last day on which SNF level of care services were required and received,

2. SNF-level services required by the resident are for a condition that was treated during the qualifying hospital stay or for a condition that arose while receiving care in the SNF for a condition for which the beneficiary was previously treated in the hospital,
3. Services must be reasonable and necessary,
4. Services can only be provided on an inpatient basis,
5. Resident must require and receive the services on a daily basis, and
6. Resident has remaining days in the SNF benefit period.

For greater detail, refer to the **Medicare Benefit Policy Manual**, Chapter 8.

6.8 Non-compliance with the SNF PPS Assessment Schedule

To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as described in Chapter 2.

According to 42 CFR 413.343, an assessment that does not have an ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent early or late assessment scheduling practices may result in a review. The default rate (AAA) takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the RUG group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

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 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

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 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 the Medicare-required assessment 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 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 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.

However, there are instances when the SNF may bill the default code when a Medicare-required assessment does not exist in the QIES ASAP system. These exceptions are:

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,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
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, 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. The 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.

When an OBRA Admission assessment does not exist, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the 5-day or the 14-day (including grace days) in order to receive full payment at the RUG category in which the resident grouped for days 1-14 **or** days 15-30. This assessment may only cover **one** payment period. If the ARD of the valid OBRA assessment falls

outside the ARD window of the 5-day and 14-day PPS assessments (including grace days), the SNF must bill the default code for the applicable payment period. For covered days associated with the Medicare-required 30-day, 60-day, or 90-day assessments, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the PPS assessment (including grace days) in order to receive full payment at the RUG category in which the resident grouped. If the ARD of the valid OBRA assessment falls outside the ARD window of the PPS assessment (including grace days), the SNF must bill the default code.

Under all situations other than exceptions 1-5, the following apply when the SNF failed to set the ARD prior to the end of the last day of the ARD window, including grace days, or later and the resident was already discharged from Medicare Part A when this was discovered:

1. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is within the ARD window of the PPS assessment (including grace days), the SNF may bill the RUG category in which the resident classified.
2. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is outside the ARD window of the Medicare-required assessment (including grace days), the SNF may not bill for any days associated with the missing PPS assessment.
3. If a valid OBRA assessment (except a stand-alone discharge assessment) does not exist in the QIES ASAP system, the SNF may not bill for any days associated with the missing PPS assessment.

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.