

**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	Residents satisfying the following two conditions: <ul style="list-style-type: none"> <li>• Having a maximum ADL dependency score of 5 or less.</li> <li>• Having behavioral or cognitive performance symptoms, involving any of the following:                             <ul style="list-style-type: none"> <li>— difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status <math>\leq 9</math>),</li> <li>— difficulty in making self understood, short term memory, or decision making (score on the Cognitive Performance Scale <math>\geq 3</math>),</li> <li>— hallucinations,</li> <li>— delusions,</li> <li>— physical behavioral symptoms toward others,</li> <li>— verbal behavioral symptoms toward others,</li> <li>— other behavioral symptoms,</li> <li>— rejection of care, or</li> <li>— wandering.</li> </ul> </li> </ul>
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**

<b>1st Digit Values</b>	<b>Assessment Type (abbreviation)</b>	<b>Standard* Scheduled Payment Period</b>
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"> <li>• No impact on the standard payment period (the assessment is not unscheduled).</li> <li>• 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.</li> <li>• If the first digit value is a 6, then the second digit value must be 0.</li> </ul>

(continued)

**Table 3. Assessment Indicator Second Digit Table (continued)**

Second Digit Values	Assessment Type	Impact on Standard Payment Period
1	Either an unscheduled OBRA assessment <b>or</b> Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> <li>• Combined with any OMRA</li> <li>• Medicare Short Stay assessment</li> </ul>	<ul style="list-style-type: none"> <li>• 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"> <li>— Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period.</li> </ul> </li> <li>• 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"> <li>— Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period.</li> </ul> </li> <li>• If the ARD of the unscheduled assessment is a grace day of a scheduled PPS assessment:                             <ul style="list-style-type: none"> <li>— Use the Medicare RUG (Z0100A) from the start of the standard payment period.</li> </ul> </li> </ul>
2	Start of Therapy OMRA Do NOT use if <ul style="list-style-type: none"> <li>• Medicare Short Stay assessment</li> <li>• Combined with End of Therapy OMRA</li> <li>• Combined with unscheduled OBRA</li> <li>• Combined with Swing Bed CCA</li> </ul>	<ul style="list-style-type: none"> <li>• If the unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A):                             <ul style="list-style-type: none"> <li>— 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.</li> </ul> </li> <li>• 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.</li> </ul>
3	Start of Therapy OMRA combined with either an unscheduled OBRA assessment <b>or</b> a Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> <li>• Medicare Short Stay assessment</li> <li>• Combined with End of Therapy OMRA</li> </ul>	<ul style="list-style-type: none"> <li>• If unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A):                             <ul style="list-style-type: none"> <li>— Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the end of standard payment period.</li> </ul> </li> <li>• 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.</li> </ul>

(continued)

**Table 3. Assessment Indicator Second Digit Table (continued)**

Second Digit Values	Assessment Type	Impact on Standard Payment Period
4	<p>End of Therapy OMRA <b>not reporting</b> Resumption of Therapy; <b>whether or not</b> combined with unscheduled OBRA assessment and <b>whether or not</b> combined with Swing Bed CCA</p> <p>Do NOT use if</p> <ul style="list-style-type: none"> <li>• Combined with Start of Therapy OMRA</li> <li>• Medicare Short Stay assessment</li> <li>• End of Therapy OMRA <b>reporting</b> Resumption of Therapy (EOT-R)</li> </ul>	<p>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.</p>
5	<p>Start of Therapy OMRA combined with End of Therapy OMRA <b>not reporting</b> Resumption of Therapy</p> <p>Do NOT use if</p> <ul style="list-style-type: none"> <li>• Medicare Short Stay assessment</li> <li>• Combined with unscheduled OBRA</li> <li>• Combined with Swing Bed CCA</li> <li>• End of Therapy OMRA <b>reporting</b> Resumption of Therapy (EOT-R)</li> </ul>	<ul style="list-style-type: none"> <li>• If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> <li>— Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date.</li> <li>— 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.</li> </ul> </li> <li>• 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.</li> </ul>
6	<p>Start of Therapy OMRA combined with End of Therapy OMRA <b>not reporting</b> Resumption of Therapy and combined with either an unscheduled OBRA assessment <b>or</b> Swing Bed CCA</p> <p>Do NOT use if</p> <ol style="list-style-type: none"> <li>1. Medicare Short Stay assessment</li> <li>2. End of Therapy OMRA <b>reporting</b> Resumption of Therapy (EOT-R)</li> </ol>	<ul style="list-style-type: none"> <li>• If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> <li>— Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date.</li> <li>— Use the unscheduled assessment non-therapy RUG (Z0150A) from the day after the latest therapy end date through the end of current payment period.</li> </ul> </li> <li>• 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.</li> </ul>
7	<p>Medicare Short Stay Assessment (see <b>Medicare Short Stay Assessment</b> below for the definition of this assessment.)</p>	<p>See <b>Medicare Short Stay Assessment</b> below for impact on payment periods.</p>

(continued)

**Table 3. Assessment Indicator Second Digit Table (continued)**

Second Digit Values	Assessment Type	Impact on Standard Payment Period
A	End of Therapy OMRA <b>reporting</b> Resumption of Therapy (EOT-R); <b>whether or not</b> combined with unscheduled OBRA assessment and <b>whether or not</b> combined with Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> <li>• Combined with Start of Therapy OMRA</li> <li>• Medicare Short Stay assessment</li> </ul>	<ul style="list-style-type: none"> <li>• 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).</li> <li>• 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.</li> </ul>
B	Start of Therapy OMRA combined with End of Therapy OMRA <b>reporting</b> Resumption of Therapy (EOT-R) Do NOT use if <ul style="list-style-type: none"> <li>• Medicare Short Stay assessment</li> <li>• Combined with unscheduled OBRA</li> <li>• Combined with Swing Bed CCA</li> </ul>	<ul style="list-style-type: none"> <li>• If unscheduled assessment gives a therapy group Medicare RUG (Z0100A):                             <ul style="list-style-type: none"> <li>— Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date.</li> <li>— 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).</li> <li>— Use the unscheduled assessment Medicare RUG (Z0100A) from the resumption of therapy date through the end of the standard payment period.</li> </ul> </li> <li>• 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.</li> </ul>
C	Start of Therapy OMRA combined with End of Therapy OMRA <b>reporting</b> Resumption of Therapy (EOT-R) and combined with either an unscheduled OBRA assessment <b>or</b> Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> <li>• Medicare Short Stay assessment</li> </ul>	<ul style="list-style-type: none"> <li>• If unscheduled assessment gives a therapy group Medicare RUG (Z0100A):                             <ul style="list-style-type: none"> <li>— Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date.</li> <li>— 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).</li> <li>— Use the unscheduled assessment Medicare RUG (Z0100A) from the resumption of therapy date through the end of the standard payment period.</li> </ul> </li> <li>• 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.</li> </ul>

(continued)

**Table 3. Assessment Indicator Second Digit Table (continued)**

Second Digit Values	Assessment Type	Impact on Standard Payment Period
D	Change of Therapy OMRA; <b>whether or not</b> combined with unscheduled OBRA assessment and <b>whether or not</b> combined with Swing Bed CCA	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Note that a Change in Therapy OMRA cannot be combined with a 5-day or readmission/return assessment.</li> </ul>

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.

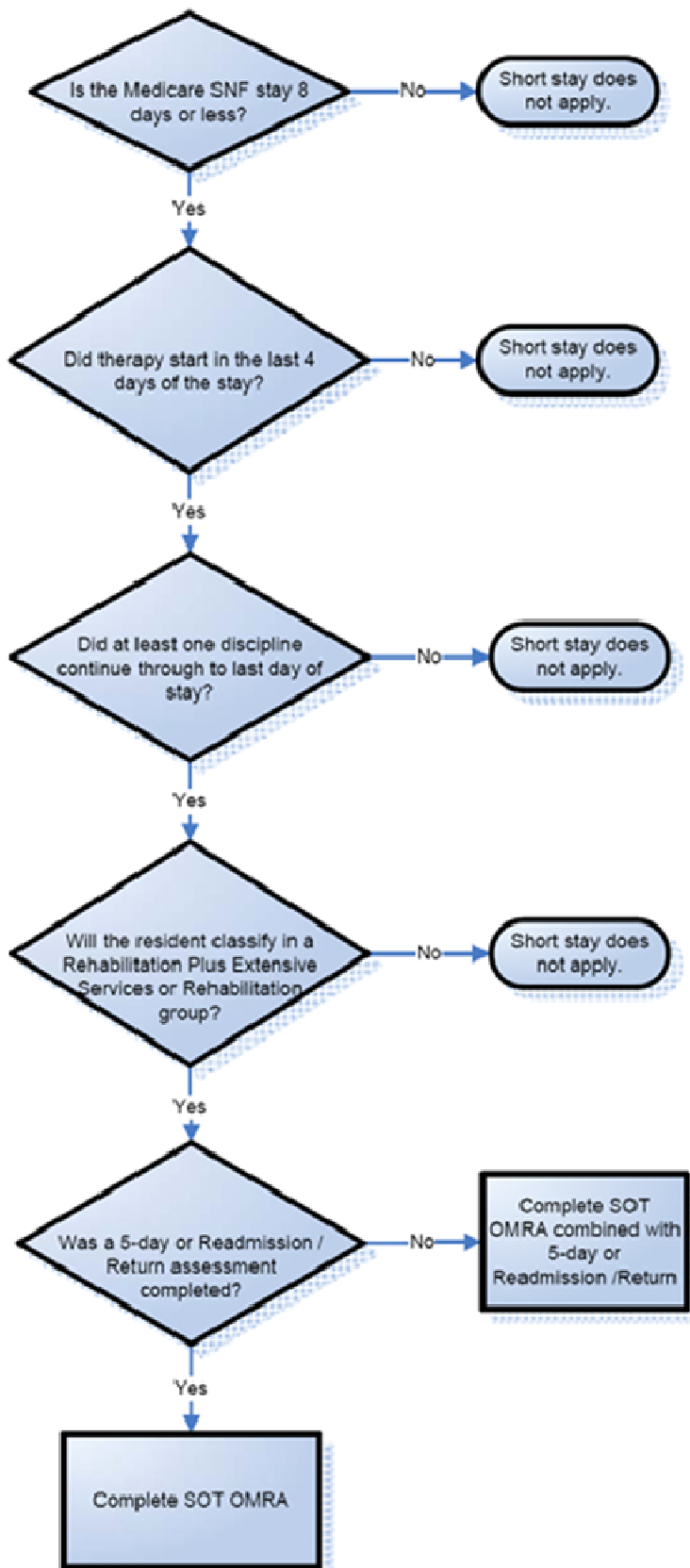
See below for Medicare Short Stay Assessment Algorithm.

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 1<sup>st</sup> 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: