Follow-up information from November 3 provider training call

I. General Clarifications

1. Clarification regarding use of the term "day of discharge"

Answer: The term "day of discharge" can serve two distinct purposes. The day of discharge may refer to the day the resident leaves the facility, as discussed in Chapter 2 of the MDS RAI manual and as captured within Item A2000 on the MDS. "Day of discharge" may also refer to the resident's discharge from Medicare Part A, which is captured in Item A2400C on the MDS. As noted in Chapter 2 of the MDS RAI manual, it is possible that these two dates, that is the date of facility discharge and the date of Part A discharge, may not be the same, such as in cases where a resident uses all of his or her 100 entitled SNF benefit days but remains in the facility for some time after that point. It is also possible that the dates listed in A2000 and A2400C may be the same, such as in cases where the resident leaves the facility prior to exhausting their SNF benefit or if the resident were to expire during the course of the stay. Whether or not these two dates overlap is important to understanding the potential billing impact associated with these dates.

As noted in Chapter 3 of the Medicare Benefit Policy Manual, the date of discharge from the facility is a Medicare non-billable day. Therefore, in cases where A2000 (discharge from facility) and A2400C (last day of Medicare Part A stay) are the same, then the last day of the Medicare stay (A2400C) is a Medicare non-billable day. In cases where the resident remains in the facility after exhausting the full Medicare benefit, then the last day of the Medicare stay, which in this case would mean that A2400C would be equivalent to 100th day of the benefit, would be a Medicare billable day.

2. Clarification regarding early assessment penalty policy

Answer: In the previous SNF PPS clarification memo posted to the CMS website, CMS outlined the appropriate timeframe for setting the ARD for both scheduled and unscheduled assessments. With regard to scheduled assessments, it was noted that the ARD for a scheduled PPS assessment must be set for a day within the allowable ARD window and that the day to be used for the ARD on the scheduled assessment must be decided by the end of the allowable ARD window for that scheduled assessment.

In response to recent questions regarding how early this decision may be made, we would note that facilities may begin to select the ARD for their scheduled assessments as early in the stay as deemed appropriate by the facility. However, we would caution facilities that choose to make ARD decisions early that the ARD sets the end of the observation period for an assessment and that this observation period is intended to be selected as the timeframe which represents most accurately the conditions and needs of the resident. Facilities should ensure that the ARD and observation period chosen for residents is reflective of the patient's current condition and not merely reflective of the facility's logistical concerns.

II. Change of Therapy (COT) OMRA

1. Clarification regarding the relationship between the Change of Therapy OMRA and the Day of Discharge

Answer: In cases where the resident is discharged from the facility on or prior to Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual.

In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to Day 7 of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met.

Finally, in cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual.

2. Clarification regarding the beginning of a COT observation period.

Answer: As noted in the FY 2012 SNF PPS proposed and final rules, the ARD for a COT OMRA is to be set 7 days following the ARD set for the most recent PPS assessment used for payment. Additionally, as noted in Section 2.9 of the MDS RAI manual, the ARD for a COT OMRA may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient's current RUG-IV therapy classification. As such, if an assessment does not yet exist for a resident which includes sufficient therapy to classify the resident for a therapy RUG, regardless of the RUG used for billing in the case of index maximization, then facilities may not complete a COT OMRA for this resident. The practical implication of this is that a COT OMRA may not be used as the first assessment that would classify a resident into a RUG-IV therapy group. This initial classification must be done using one of the regularly scheduled assessments or by completing a Start of Therapy OMRA.

3. Clarification regarding completion of interview items on COT OMRA

Answer: As stated in the previous SNF PPS clarification memo posted to the CMS website, providers completing a COT OMRA may complete the interview items one or two days after Day 7 of the COT observation period – the ARD for the COT OMRA. We do not expect this will be necessary in all cases, as providers should be continually monitoring the progress of residents toward meeting the requirements of the RUG-IV therapy category to which they have been assigned.

We would also note that providers should not routinely dash interview items or substitute the staff assessment for the resident interview due to either logistical concerns or in cases where a separate PPS assessment which included the interview items was completed recently. While additional assessments have been added to the SNF PPS, CMS regards the frequency of interviews and the manner in which they are conducted to be sufficiently within the control of providers to ensure that the assessments are completed as fully and accurately as possible without compromising the integrity of the assessment or the ability of the resident to speak for themselves.

4. Clarification regarding when a COT evaluation should be completed.

Answer: While in the current MDS RAI manual, it states that a COT evaluation should only be conducted at the end of the week, this refers to the length of time that should be reviewed in the COT evaluation process. However, we would encourage facilities not to wait until the seventh day or later to conduct a review of the therapy provided to their residents and to continuously monitor therapy provision within the facility. By continually monitoring the therapy that is being provided, facilities will be in a better position to identify issues as they arise and ensure that residents are receiving a level of therapy consistent with their condition and needs.

III. End-of-Therapy (EOT) OMRA

1. Clarification regarding requirements for completing an EOT OMRA.

Answer: In accordance with the MDS RAI manual, an EOT OMRA is necessary in cases where a resident classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category and does not receive any therapy services for three or more consecutive calendar days. As such, an EOT OMRA is not necessary for residents who have not yet been classified into such a RUG category on a scheduled or unscheduled PPS assessment. Furthermore, for residents who do not receive therapy for three consecutive calendar days during the allowable ARD window for the 5-day scheduled PPS assessment, facilities are not required to adjust the date of the ARD for the 5-day assessment or to combine the 5-day assessment with an EOT OMRA.

2. Clarification regarding the relationship between the End of Therapy OMRA and the Day of Discharge

Answer: In cases where a resident classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category and does not receive any therapy services for three or more consecutive calendar days and the resident is discharged from the facility on the third day of missed therapy services, then no EOT OMRA is required. More precisely, in cases where the date coded for Item A2000 is the third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual.

In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT

OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required.

Finally, in cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual.

3. Clarification regarding how to bill an End-of-Therapy OMRA reporting Resumption.

Answer: In cases where a facility completes an End-of-Therapy (EOT) OMRA reporting a Resumption of Therapy (EOT-R), the facility should bill the days covered by that assessment in the following manner. The AI code chosen for this assessment will have a second character of A, B, or C as these are the only second characters related to an EOT OMRA reporting resumption. The first character of the AI code will be chosen based on if this assessment is combined with a scheduled PPS assessment or completed as a stand-alone assessment. This AI code is then attached to the three character non-therapy RUG code, to form the five character HIPPS code, determined by the information coded on the assessment for those days when the resident did not receive therapy and would be attached to the three character therapy RUG code found on the most recent PPS assessment used for payment which included a therapy RUG beginning the day that therapy resumes.

Consider the following example. A resident, Mr. P, is admitted on 10/01/11. The ARD of the 5-day assessment for Mr. P is set for 10/07/11 (Day 7) and the RUG assigned to Mr. P is RVB. The ARD of the 14-day assessment is set for 10/14/11 (Day 14) and the RUG assigned to Mr. P is again RVB. Due to an acute illness, Mr. P is unable to receive therapy services from 10/18/11 through 10/21/11, but is expected to resume therapy on 10/22/11 under the same therapy regimen. The facility completes an EOT for Mr. P with an ARD of 10/20/11 and reports that the resumption of therapy will occur on 10/22/11. The EOT OMRA assigns Mr. P a non-therapy RUG of CE2. Mr. P is discharged from the facility on 10/28/11.

In the case described above, assuming no intervening assessments were necessary, the facility would bill in the following manner. Days 1-14 would be billed under HIPPS code RVB10. Days 15-17 would be billed under HIPPS code RVB20. Days 18-21 would be billed under HIPPS code CE20A. Days 22-27 would be billed under HIPPS code RVB0A.

4. Clarification regarding the definition of a resumption of therapy.

Answer: In terms of billing a resumption of therapy, the FY 2012 SNF PPS final rule and MDS RAI manual outline that providers should bill the therapy RUG that was in effect prior to the break in therapy, as discussed above in clarification III.2. To be considered an appropriate resumption of therapy, two qualifications must be met. First, the resident must resume therapy at the same RUG-IV therapy level as was in effect prior to the break in therapy. For example, if the resident was last billed at Very-High rehabilitation, then the resident must resume at Very-High rehabilitation. Second, the resident's previous therapy plan must still be in effect. For example,

if the resident qualified for Very-High rehabilitation on the basis of receiving Physical and Occupational therapies, then these disciplines must resume at the same intensity as prior to the break in therapy. If, for a given resident, one or both of these two conditions are not met, then an EOT-R may not be completed for that resident. For example, if the resident would resume at Very-High rehabilitation, but instead of receiving Physical and Occupational therapies the resident is expected to receive Occupational and Speech-Language therapies, then this would not constitute a legitimate resumption and an EOT-R could not be completed.

It should further be noted that, with regard to a patient's ability to resume therapy at the same RUG-IV therapy level, facilities may want to wait to submit assessments until 7 days from the day of resumption, in order to ensure that the resident has resumed therapy at the same therapy level. Cases where a resumption of therapy is reported and a different RUG-IV level is seen seven days later could lead to increased review of associated claims and assessments.

5. Clarification regarding a change in ADLs related to an EOT-R

Answer: In all cases where an EOT-R would be completed, the resident must resume therapy at the same RUG-IV therapy level as had been in effect prior to the break in therapy. However, it is possible that the ARD for an EOT OMRA reporting resumption may be set for the first grace day of the allowable grace days for a scheduled PPS assessment, while the ARD for the scheduled assessment was set for a day within the normal ARD window. In this limited subset of cases, the resumption of therapy should occur using the previous RUG-IV therapy level (which should be the same as the therapy level determined on the scheduled PPS assessment if the resumption is appropriate) but using the Activities of Daily Living (ADL) score from the most recent PPS assessment.

Consider the following example. A resident, Mr. P, is admitted on 10/01/11. The ARD of the 5-day assessment for Mr. P is set for 10/07/11 (Day 7) and the RUG assigned to Mr. P is RVB. The ARD of the 14-day assessment is set for 10/14/11 (Day 14) and the RUG assigned to Mr. P is again RVB. The ARD of the 30-day assessment is set for 10/28/11 (Day 28) and the RUG assigned to Mr. P is now RVA. Due to an acute illness, Mr. P is unable to receive therapy services from 10/29/11 through 10/31/11, but is expected to resume therapy on 11/2/11 under the same therapy regimen. The facility completes an EOT for Mr. P with an ARD of 10/31/11 and reports that the resumption of therapy will occur on 11/2/11. The EOT OMRA assigns Mr. P a non-therapy RUG of CE2. Mr. P is discharged from the facility on 11/12/11.

In the case described above, assuming no intervening assessments were necessary, the facility would bill in the following manner. Days 1-14 would be billed under HIPPS code RVB10. Days 15-28 would be billed under HIPPS code RVB20. Days 29-31 would be billed under HIPPS code CE20A. Days 32-41 would be billed under HIPPS code RVA0A.

This represents the one and only occasion where the three character RUG-IV therapy RUG code may differ from that which was billed prior to the break in therapy, and the difference may only be in the third character in the therapy RUG code related to the resident's ADL score.