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6	6.4	6-10	• In cases of an EOT-R when the therapy end date is in one payment period and the resumption date is in the next payment period, the facility should bill the non-therapy RUG given on the EOT OMRA beginning the day after the patient's last therapy session and begin billing the therapy RUG that was in effect prior to the EOT OMRA beginning on the day that therapy resumed (O0450B). If the resumption of therapy occurs after the next billing period has started, then this therapy RUG should be used until modified by a future scheduled or unscheduled assessment. For example, a resident misses therapy on Days 11, 12, and 13 and resumes therapy on Day 15. In this case the facility should bill the non-therapy RUG for Days 11, 12, 13, and 14 and on Day 15 the facility should bill the RUG that was in effect prior to the EOT.
6	6.4	6-11 to 6-14	Page length change.
6	6.4	6-16	• 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 (O0450B) through the end of the standard payment period in which the resumption of therapy occurs.
6	6.4	6-18	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) not including the start of therapy date.** 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	6.4	6-20	Added text to text box. 5. Must be no more than 3 days after the start of therapy, not including the start of therapy date.
6	6.6	6-25	For Speech-Language Pathology Services (Items at O0400A), Occupational Therapy (Items at O0400B), and Physical Therapy (Items at O0400C), the MDS 3.0 separately captures minutes that the resident was receiving individual, concurrent, and group therapy (see Chapter 3, Section O for definitions) during the last 7 days. For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy. 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

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			~~FY2011 Medicare Part A and~~ non-Medicare classification. ~~Beginning with federal FY2012~~ For Medicare Part A classification, the total minutes used for RUG-IV classification include all minutes in individual therapy, one-half the minutes in concurrent therapy, and 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.~~
6	6.6	6-25	**STEP # 1** Add the individual minutes (O0400A1) and one-half of the concurrent minutes (O0400A2). Add all of the group minutes (O0400A3) for non-Medicare classification or ~~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 for Medicare classification and record as Total Minutes. Total Minutes* = _____ ~~When~~ For Medicare classification 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 of O0400A3) ~~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* = _____
6	6.6	6-26	**STEP # 2** Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). Add all of the group minutes (O0400B3) for non-Medicare classification or ~~If~~

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			~~classification is for Medicare for FY2011 add all of the group minutes (O0400B3) and record as Total Minutes. Otherwise beginning with FY 2012, add~~ one-quarter of the group minutes for Medicare classification and record as Total Minutes. Total Minutes* = _____ For Medicare classification, ~~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 of O0400B3) ~~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.
6	6.6	6-26	**STEP # 3** Add the individual minutes (O0400C1) and one-half of the concurrent minutes (O0400C2). Add all of the group minutes (O0400C3) for non-Medicare classification or ~~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 for Medicare classification and record as Total Minutes. Total Minutes* = _____ ~~When~~ For Medicare classification, 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 of O0400C3) ~~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.
6	6.6	6-29	5. **The ARD (Item A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date**

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			(Items O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date. 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	6.8	6-52 to 6-54	**Early Assessment** In the case of an early COT OMRA, the early COT would reset the COT calendar such that the next COT OMRA, if deemed necessary, would have an ARD set for 7 days from the early COT ARD. For example, a facility completes a 30-day assessment with an ARD of November 1 which classifies a resident into a therapy RUG. A COT OMRA is completed for this resident with an ARD set for November 6, which is Day 5 of the COT observation period as opposed to November 8 which is Day 7 of the COT observation period. This COT OMRA would be considered an early assessment and, based on the ARD set for this early assessment would be paid at the default rate for the two days this assessment was out of compliance. The next seven day COT observation period would begin on November 7, and end on November 13. **Late Assessment** If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified. If the ARD on the late assessment is set for **prior to the end of the period during which the late assessment would have controlled the payment,** had the ARD been set timely, and/or **no intervening assessments have occurred**, **the SNF will bill the default rate for the number of days that the assessment is out of compliance.** This is equal to the number of days between the day following the last day of the available ARD window (including grace days when appropriate) and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment.** For example, a Medicare-required 30-day assessment with an ARD of Day 41 is out of compliance for 8 days and therefore would be

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			paid at the default rate for 8 days and the HIPPS code from the late 30-day assessment until the next scheduled or unscheduled assessment that controls payment. In this example, if there are no other assessments until the 60-day assessment, the remaining 22 days are billed according to the HIPPS code on the late assessment. A second example, involving a late unscheduled assessment would be if a COT OMRA was completed with an ARD of Day 39, while Day 7 of the COT observation period was Day 37. In this case, the COT OMRA would be considered 2 days late and the facility would bill the default rate for 2 days and then bill the HIPPS code from the late COT OMRA until the next scheduled or unscheduled assessment controls payment, in this case, for at least 5 days. NOTE: In such cases where a late assessment is completed and no intervening assessments occur, the late assessment is used to establish the COT calendar. If the ARD of the late assessment is set **after the end of the period during which the late assessment would have controlled payment,** had the assessment been completed timely, or in cases where **an intervening assessment** has occurred and the resident is still on Part A, the provider must still complete the assessment. The ARD can be no earlier than the day the error was identified. **The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely 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 a different Medicare-required assessment. In the example above, the SNF would also need to complete the 30-day Medicare-required assessment within Days 27-33, which includes grace days. The 30-day assessment would cover Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services. In this example, the late 14-day assessment would not be considered an assessment used for payment and would not impact the COT calendar, as only an assessment used for payment can affect the COT calendar (see section 2.8). A second example involving an unscheduled assessment would be the following. A 30-day assessment is completed with an ARD of Day 30. Day 7 of the COT observation period is Day 37. An

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			EOT OMRA is performed timely for this resident with an ARD set for Day 42 and the resident's last day of therapy was Day 39. Upon further review of the resident's record on Day 52, the facility determines that a COT should have been completed with an ARD of Day 37 but was not. The ARD for the COT OMRA is set for Day 52. The late COT OMRA should have controlled payment from Day 31 until the next assessment used for payment. Because there was an intervening assessment (in this case the EOT OMRA) prior to the ARD of the late COT OMRA, the facility would bill the default rate for 9 days (the period during which the COT OMRA would have controlled payment). The facility would bill the RUG from the EOT OMRA as per normal beginning the first non-therapy day, in this case Day 40, until the next scheduled or unscheduled assessment used for payment. ~~The SNF must complete a late assessment if the SNF fails to set the ARD within the defined ARD window for a scheduled Medicare-required assessment (including the grace days) or an OMRA when the resident is still on Part A coverage. The ARD can be no earlier than the day the omission was identified. If the ARD on the late assessment is set prior to the end of the payment period for which the Medicare-required assessment would have been effective, the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the HIPPS rate code established by the late assessment. For example, a Medicare-required 30-day assessment with an ARD of Day 41 would be paid the default rate for Days 31 through 40 and at the HIPPS classification from the assessment beginning on Day 41.~~ ~~If the ARD of the late assessment is set after the end of the payment period for which the Medicare-required assessment would have been effective 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.~~

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			Missed Assessment If the SNF fails to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window, including grace days, and the resident is no longer a SNF Part A resident, and as a result a Medicare-required assessment does not exist in the QIES ASAP for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP. When an assessment does not exist in the QIES ASAP, there is not an assessment based RUG the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid assessment that is accepted into the QIES ASAP. The provider must bill the RUG category that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, an assessment may not be performed.
6	6.8	6-55	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. In the case of an unscheduled assessment if the SNF fails to set the ARD for an unscheduled PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment is missed and cannot be completed. All days that would have been paid by the missed assessment (had it been completed timely) are considered provider-liable. However, as with late unscheduled assessment policy, the provider-liable period only lasts until the point when an intervening assessment controls the payment.