Billing Of OMRAs and Achieving Accurate Billing Outcomes

WHCA October 2013

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Chief Clinical Officer

General Billing Requirements

Medicare Claims Processing Manual

- Occurrence Code 50 required for each assessment period represented on the claim.
- Date of service reported with OC 50 must contain the ARD of each assessment.
- OC 50 only need appear once for assessments that produce 2 different billing HIPPS codes.

General Billing Requirements

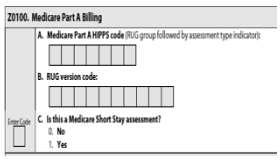
Medicare Claims Processing Manual

- HCPCS/Rates field must contain a 5-digit HIPPS Code.
- **SNF providers must bill the HIPPS codes on the claim form in the order in which the beneficiary received that level of care.**

HIPPS Codes

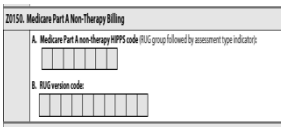
- 5-digit billing code
  - First 3 digits contain the RUG group
  - Last 2 positions contain a 2-digit assessment indicator (AI) code.

Z0100A Part A RUG



- Used to bill majority of SNF Part A claims.
- Used for all scheduled assessments
- Used for all COT, SOT assessments

Z0150 – Non Therapy RUG



- Used to bill when an EOT OMRA is completed
- May also be used to bill non-therapy days when a Short Stay is completed.

Billing HIPPS Codes

- The HIPPS rate code that appears on the claim must match the assessment that has been transmitted and accepted by the QIES ASAP System.

Billing HIPPS Codes

- SNFs may bill the program only after:
  - An assessment has been completed and submitted to the State RAI Database;
  - A Final Validation Report indicating that the assessment has been accepted by the system; and
  - The covered day has actually been used

AI Codes

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

AI Codes

2nd Digit	Short Descriptor
0	Scheduled PPS Assessment
1	Unscheduled OBRA
2	Start of Therapy OMRA
3	SOT and Unscheduled OBRA
4	EOT OMRA
5	SOT and EOT OMRA
6	SOT, EOT OMRA combined with Unsched. OBRA
7	Medicare Short Stay Assessment
A	EOT – Resumption
B	SOT/EOT with Resumption
C	SOT/EOT with Resumption and Unsched. OBRA
D	Change of Therapy (COT)

Scheduled Assessments

Assessment Type	Applicable Payment Day
5-day or Readmission/return	Days 1 - 14
14-day	Days 15– 30
30-day	Days 31 – 60
60-day	Days 61 - 90
90-day	Days 91 -100

Scheduled Assessments

Medicare Covered Claim

42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	PPS Medicare	RUC10		1			
0022	PPS Medicare	RUB20		16			
0022	PPS Medicare	RVB30		12			
0120	Semi Private	250.00		29	7000.00		
0250	Pharmacy			1	1250.00		
0300	Laboratory			1	125.00		
0420	Physical Therapy			20	4000.00		
0430	Occupational Therapy			20	3000.00		

Unscheduled Assessments

Any of the following types of unscheduled assessments can alter they payment schedule.

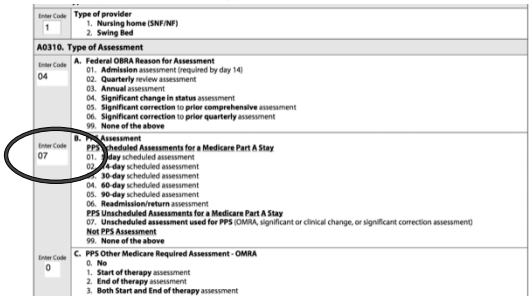
Assessment Type	Payment Effective Date
SCSA (Significant Change)	**On ARD** (in most cases)
SOT (Start of Therapy)	**Earliest Therapy Start Date**
EOT (End of Therapy)	**First non-therapy day.**
EOT-R (Resumption of Therapy)	**Resumption Date indicated in O0450**
COT (Change of Therapy)	**1st day of COT Evaluation period (retro. 7 days)**

SCSA

- One of the OBRA required assessments that can impact payment.
- Required when resident meets definition for a significant change.
- Payment changes on ARD unless grace day used and combined with scheduled PPS Assessment.
- Requires appropriate billing of the MDS in A0310.

SCSA – Proper Coding of A0310

(on Medicare Covered Stay)



Enter Code 1 — **Type of provider**
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code 04 — **A. Federal OBRA Reason for Assessment**
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

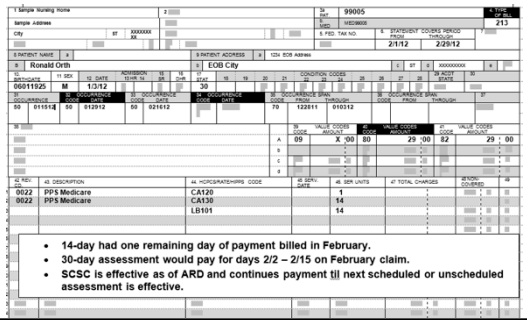
Enter Code 07 — **B. PPS Assessment**
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **None of the above**

Enter Code 0 — **C. PPS Other Medicare Required Assessment - OMRA**
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

SCSA Example

- Resident admitted on 1/3/12
- 5-day and 14-day assessments completed according to schedule
- 30-day assessment completed on Day 27 (1/29). - CA1
- Significant Change in Status assessment completed on 2/16 – LB1

SCSA Claim Example



- **14-day had one remaining day of payment billed in February.**
- **30-day assessment would pay for days 2/2 – 2/15 on February claim.**
- **SCSC is effective as of ARD and continues payment til next scheduled or unscheduled assessment is effective.**

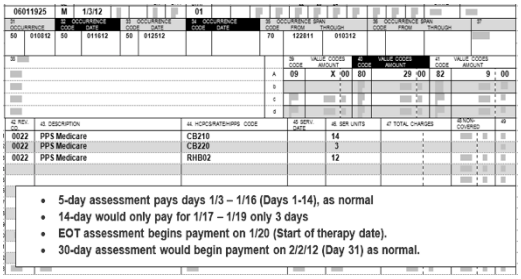
SOT OMRA

- Optional assessment to obtain Rehab RUG when not currently in a Rehab RUG and therapy services initiated.
- ARD must be 5-7 days from the earliest Start of Therapy date in Section 0 of MDS 3.0.
- Rehab RUG payment effective as of start of therapy date.
- Also a requirement if completing a Short Stay Assessment
  - Never code 5-day assessment as an SOT unless a Short Stay Assessment is desired.
  - Watch your modifier
    - Ends in 7 if short stay
    - Ends in 2 if SOT OMRA

SOT OMRA Example

- Resident Admitted 1/3
- 5-day assessment, 1/8 CB2
- 14-day assessment, 1/16 CB2
- Therapy initiated on 1/20
- SOT completed, ARD 1/25, RHB
- 30-day Assessment, 1/29 RVB

SOT OMRA Claim Example



42 REV CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV DATE	46 SER UNITS	47 TOTAL CHARGES	48 NON-COVERED
0022	PPS Medicare	CB210		14		
0022	PPS Medicare	CB220		3		
0022	PPS Medicare	RHB02		12		

- 5-day assessment pays days 1/3 – 1/16 (Days 1-14), as normal
- 14-day would only pay for 1/17 – 1/19 only 3 days
- EOT assessment begins payment on 1/20 (Start of therapy date).
- 30-day assessment would begin payment on 2/2/12 (Day 31) as normal.

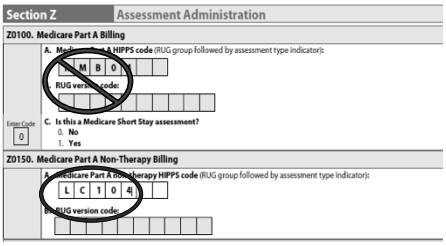
EOT OMRA

- Required under 2 circumstances
  - Resident currently in Rehab RUG and all therapy ends, skilled coverage to continue
  - Resident in Rehab RUG does not received therapy services on 3 consecutive calendar days.
    - EOT assessments need only be completed if resident currently classified into a Rehab RUG.

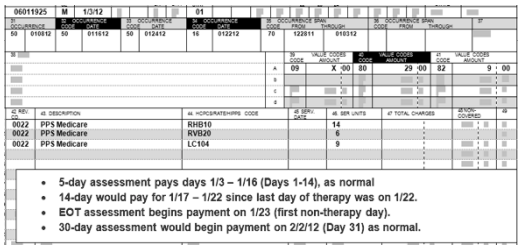
EOT OMRA

- Resident admitted on 1/3/12
- 5-day assessment, 1/8 RHB
- 14-day Assessment, 1/16 RVB
- All therapy ended on 1/22
- EOT completed, ARD 1/24 LC1

EOT OMRA



EOT OMRA Claim Example



Error in Billing EOT

	42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47 TOTA
1	0022	PPS Medicare	RHB10		10	
2	0022	PPS Medicare	RVB20		4	
3	0022	PPS Medicare	RMB04		14	
4	0120	Semi Private	250.00		27	

EOT -R

End of Therapy Resumption

Requirements for completion:

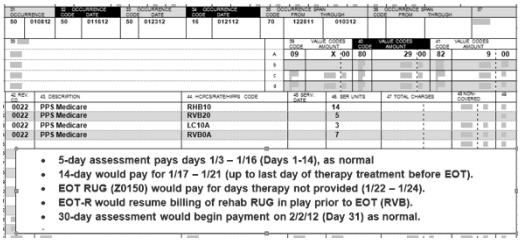
1. Therapy resumes within 5 calendar days of last treatment date
2. Therapy resumes at same level of intensity.

Payment at the same Rehab RUG level begins on therapy resumption date.

EOT - R Example

- Resident admitted on 1/3/12
- 5-day assessment, 1/8 RHB
- 14-day Assessment, 1/16 RVB
- Resident misses therapy on 1/22, 1/23 and 1/24
- EOT completed, ARD 1/23 LC1
- Therapy Resumes 1/25, EOT-R completed, RVB resumes

EOT –R Claim Example



42 REV.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45. SERV. DATE	46. SER. UNITS	47. TOTAL CHARGES	48 NON-COVERED	49
0022	PPS Medicare	RHB10		14			
0022	PPS Medicare	RVB20		5			
0022	PPS Medicare	LC10A		3			
0022	PPS Medicare	RVB0A		7			

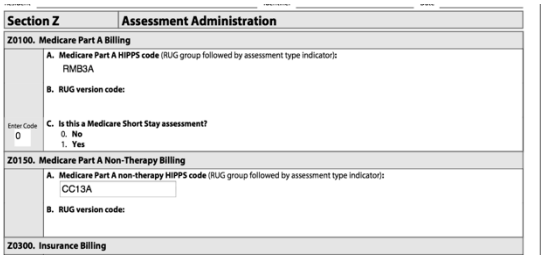
- 5-day assessment pays days 1/3 – 1/16 (Days 1-14), as normal
- 14-day would pay for 1/17 – 1/21 (up to last day of therapy treatment before EOT).
- EOT RUG (Z0150) would pay for days therapy not provided (1/22 – 1/24).
- EOT-R would resume billing of rehab RUG in play prior to EOT (RVB).
- 30-day assessment would begin payment on 2/2/12 (Day 31) as normal.

EOT – R Billing Consideration

Example

- *Resident Admitted 1/15*
- *5-day assessment 1/22 – RVB10*
- *14-day/COT 1/29 – RUB2D*
- *Resident misses therapy on 2/10, 2/11 and 2/12*
  - *Days 27, 28 and 29*
- *30-day/EOT completed 2/14 (CC1)*
  - *Day 31*
- *Therapy resumed on day 31 (EOT-R)*

EOT – R Billing Consideration



Section Z	Assessment Administration
Z0100. Medicare Part A Billing	
	A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator): RMB3A
	B. RUG version code:
Enter Code 0	**C. Is this a Medicare Short Stay assessment?** 0. **No** 1. **Yes**
Z0150. Medicare Part A Non-Therapy Billing	
	A. Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator): CC13A
	B. RUG version code:
Z0300. Insurance Billing	

EOT – R Incorrect Claim

42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47
0022	PPS Medicare	RUB2D		10	
0022	PPS Medicare	CC13A		4	
0022	PPS Medicare	RMB3A		14	
0120	Semi Private	250.00		27	
0180	Leave of Absence			1	

EOT – R Billing Consideration

From RAI Manual

- *In cases 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 last day of therapy treatment 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.*

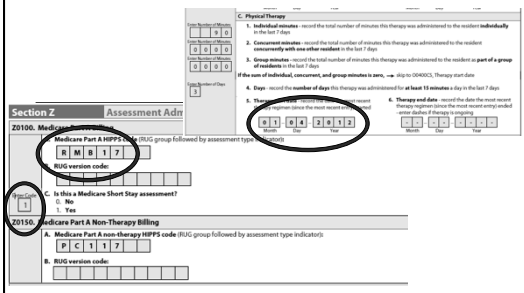
EOT – R Correct Claim

42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47 TOT
0022	PPS Medicare	RUB2D		10	
0022	PPS Medicare	CC13A		4	
0022	PPS Medicare	RUB0A		14	
0120	Semi Private	250.00		27	

Short Stay Example

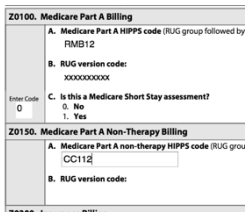
- Resident Admitted on 1/3/12
- Therapy started on 1/4/12
- Received therapy on 1/4, 1/5 and 1/6.
- Discharged to hospital on 1/7.
- Qualifies for short stay assessment.

Short Stay Example

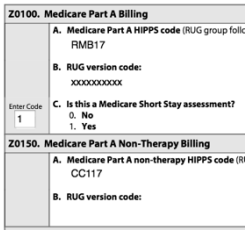


Watch HIPPS Codes

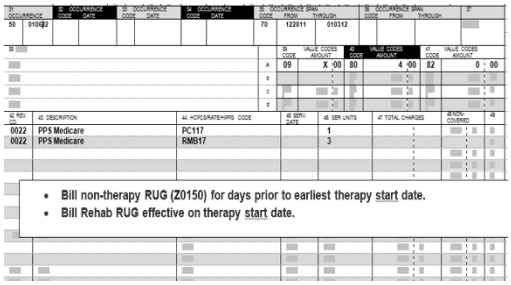
No Short Stay



Short Stay



Short Stay Claim Example



42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45. SERV. DATE	46. SER. UNITS	47. TOTAL CHARGES	48. NON-COVERED	49
0022	PPS Medicare	PC117		1			
0022	PPS Medicare	RMS17		3			

- **Bill non-therapy RUG (Z0150) for days prior to earliest therapy start date.**
- **Bill Rehab RUG effective on therapy start date.**

Change of Therapy (COT)

Required when intensity of therapy changes from current therapy RUG level.

Evaluated every 7 days (COT Evaluation periods)

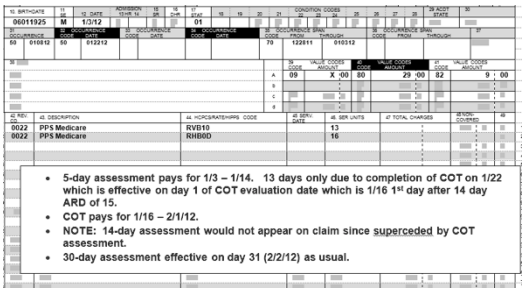
Day 1 is first day after most recently completed medicare payment assessment.

If completed, new RUG is effective first day of COT evaluation period (retroactive payment 7 days).

Change of Therapy (COT)

Admitted 1/3/12
5-day 1/8/12, RVB
14-day 1/15, RVB
COT Evaluation period 1/16 – 1/22
COT completed 1/22, RHB
30-day completed on 1/30/12, RHB

COT Example



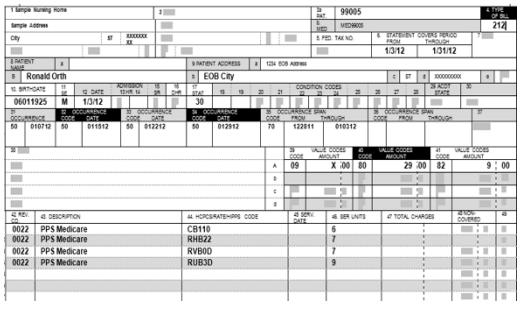
42 REV CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV DATE	46 SER UNITS	47 TOTAL CHARGES	48 NON-COVERED
0022	PPS Medicare	RVB10		13		
0022	PPS Medicare	RHB0D		16		

- **5-day assessment pays for 1/3 – 1/14. 13 days only due to completion of COT on 1/22 which is effective on day 1 of COT evaluation date which is 1/16 1st day after 14 day ARD of 15.**
- **COT pays for 1/16 – 2/1/12.**
- **NOTE: 14-day assessment would not appear on claim since superceded by COT assessment.**
- **30-day assessment effective on day 31 (2/2/12) as usual.**

Combination Example

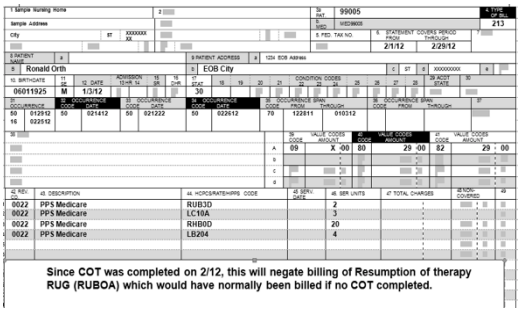
- Resident admitted 1/3/12
- 5-day assessment completed on 1/7 = CB1
- SOT/14 day assessment completed on 1/15, RHB
- COT assessment completed on 1/22, RVB
- 30-day/COT assessment completed on 1/29, RUB
- EOT completed 2/4, LC1 (Last day of therapy 2/3).
- Therapy resumed on 2/6 (EOT-R).
- COT completed on 2/12, RMB
- All therapy discontinued on 2/25.
- EOT completed 2/26 due to resident remaining on Medicare Skilled coverage, LB2

Comb. Claim Example



42 REV CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV DATE	46 SER UNITS	47 TOTAL CHARGES	48 NON-COVERED
0022	PPS Medicare	CB110		6		
0022	PPS Medicare	RHB22		7		
0022	PPS Medicare	RVB0D		7		
0022	PPS Medicare	RUB3D		9		

Comb. Claim Example



42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SER. UNITS	47 TOTAL CHARGES	48 NON-COVERED
0022	PPS Medicare	RUB3D		2		
0022	PPS Medicare	LC10A		3		
0022	PPS Medicare	RHB0D		20		
0022	PPS Medicare	LB204		4		

Since COT was completed on 2/12, this will negate billing of Resumption of therapy RUG (RUBOA) which would have normally been billed if no COT completed.

Submitting "Clean Claims"

Clean Claim

- One that holds up to FI edits
- Claims paid within 30 days, not before 14 days
- Decrease claims Returned to Provider (RTP)
- Reduces chance of Medical Review
- Increases cash flow of facility
- Reduces # of adjustment claims

Submitting "Clean Claims"

<u>It's a Team Effort</u>

- # covered days, non-covered days
- Verify LOA days
- Ancillary Charges, supported by Medical Record
  - Include ALL covered ancillary charges paid by facility.
- Verify and update ICD-9 Codes with each claim
- Communication of skilled vs. non-skilled levels of care

Submitting "Clean Claims"

It's a Team Effort

- Ensure preadmission verification complete
- Resident Name, Medicare #
- HIPPS Codes, including approp. Modifier
  - Ensure MDSs are submitted and accepted PRIOR to billing
- Assessment Reference Dates
- Ensure MDSs are submitted and accepted PRIOR to billing
- # days

Error Types

- Technical Errors
  - Miscoding modifiers
  - Incorrect service dates
  - Missed ancillary charges
  - Incorrect Service Units (days billed)
- Process Errors
  - Missed MDS assessments e.g., OMRA, 30-day
  - Data entry error e.g., therapy minutes
  - MDS not submitted
  - **Relying solely on Billing Report from MDS System**
- Documentation Errors
  - Incorrect ADL scoring
  - Incomplete or missing progress notes

Triple Check Meeting

- Occurs each month following the close of the billing cycle
- Required Attendees
  - Business Office Manager
  - Clinical Designee (MDS Coordinator)
  - Rehab Designee
- Draft UB04's should be distributed prior to scheduled meeting for review.

Triple Check Meeting

- Materials
  - Draft UB04's
  - Medicare Resident Listing
  - Therapy Service logs
  - Invoices for non-therapy ancillary services
  - Medical Record
  - Certs/Recerts
- Note: Managed Care review may require additional materials

AR Responsibilities

- Distribute draft UB04 claims to Rehab and Clinical designees no later than the 5th business day following month end
- Schedule Triple Check Meeting (ideally within 24-48 hours of draft claims distribution)
- Date span of UB04 verified
- Verification of resident data (HIC # etc.)
- Qualifying hospital stays verified
- Ancillary services
- Pharmacy services

Process

- Verify resident information against the CWF
- Verify hospital stay via hospital records
- Match admission date with census logs
- Reconcile all ancillary and pharmacy charges against invoices

Nursing Responsibilities

- Cert/Re-cert forms complete
- Chart review reflects ancillary services ordered by physician and delivered
- MDS ARD's match UB04 service dates (OC 50)
  - Admission dates matches clinical record
  - Assure schedule accounts for LOA's
- MDS Type correspond with UB04 AI indicators
- All required MDS assessments transmitted
- All required MDS assessments are reflected on the UB
- Diagnosis support medical/skilled services
- NOMNC and/or Denial of Benefits letters issued when applicable

Process

- Assure all physician certifications are complete
  - Dates
  - Reason for skilled services
  - Signatures
- Chart Review
  - MD ordered/delivered ancillary services
  - Admission Date
  - Diagnosis Codes
  - Nursing documentation

Process (cont.)

- MDS assessments (scheduled and unscheduled) with appropriate ARD's, RUG assignment, Coverage Days
  - EOTs
  - EOT-Rs
  - SOTs
  - COTs
- NOMNC and/or Denial of Benefits letters issued and signed when applicable

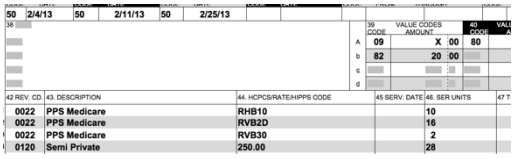
Rehab Responsibilities

- Days for therapy disciplines match UB04
- Therapy orders present and current
- Diagnosis support skilled therapy services
- Therapy documentation support need for skilled services

Process

- Review therapy logs to reconcile days and minutes per discipline
- Review COT dates to ensure no missed COTs
- Review requirements for EOT assessments, if applicable
  - 3 missed days of therapy
- Review medical record for therapy orders
- Diagnosis codes support all services and any changes during Medicare stay
- Agreement with scheduled and unscheduled MDS assessments
- Documentation – therapy progress notes

Can you spot the issue?



50	2/4/13	50	2/11/13	50	2/25/13

39 VALUE CODES CODE	AMOUNT		40 CODE
A 09	X	00	80
b 82	20	00	
c			
d			

42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47 T
0022	PPS Medicare	RHB10		10	
0022	PPS Medicare	RVB2D		16	
0022	PPS Medicare	RVB30		2	
0120	Semi Private	250.00		28	

Can you spot the issue?

OCCURRENCE CODE	DATE	30 OCCURRENCE CODE	DATE	31 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE
	081413	50	082013	50	090313			70	080313	080713	

BARRITT, ELIZABETH L.
36 GRAND AVE.

39 CODE	VALUE CODES	AMOUNT	40 CODE	VA
09		2,960.00	80	

ESTERN SPRINGS, IL 60558

REV CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV DATE	46 SERV UNITS	4
22	REHABILITATION ULTRA HIG	RUB10		14.00	
22	REHABILITATION ULTRA HIG	RUB20		7.00	
22	REHABILITATION VERY HIGH	RVB3D		4.00	
10	ROOM AND BOARD (AUG)	37500		25.00	
50	PHARMACY			10.00	
00	LAB			1.00	
20	PHYSICAL THERAPY			22.00	
24	PHYSICAL THERAPY			1.00	
30	OCCUPATIONAL THERAPY			21.00	
34	OCCUPATIONAL THERAPY			1.00	

Can you spot the issue?

50	2/4/13	50	2/11/13	50	2/25/13								

39 CODE	VALUE CODES AMOUNT	40 CODE	VA
A 09	X 00	80	
b 82	20 00		
c			
d			

42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47
0022	PPS Medicare	RHB10		10	
0022	PPS Medicare	RVB20		16	
0022	PPS Medicare	RVB30		2	
0120	Semi Private	250.00		28	

Can you spot the issue?

Resident Admitted 2/1
Discharged 2/4
Short Stay Assessment Completed
Therapy Started 2/5

42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47 TOTAL CH
0022	PPS Medicare	RMB17		4	
0120	Semi Private	250.00		4	7

Can you spot the issue?

Resident Admitted 2/1
Discharged 2/7
Did not qualify for short stay
Therapy Started 2/2

42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47 TO
0022	PPS Medicare	RMB12		6	
0120	Semi Private	250.00		6	

Can you spot the issue?

50	2/4/13	50	2/11/13	50	2/25/13						

38

	39 CODE	VALUE CODES AMOUNT		40 CODE	VA
A	09	X	00	80	
b	82	20	00		
c					
d					

	42 REV. CD.	43. DESCRIPTION	44. HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46. SER UNITS	47
1	0022	PPS Medicare	RHB10		10	
2	0022	PPS Medicare	RVB2D		12	
3	0022	PPS Medicare	RMB34		6	
4	0120	Semi Private	250.00		28	

Can you spot the issue?

May Claim	June Claim
Resident Admitted 5/17	• COT ARD 6/4
• RUC10 14 • RUB20 3	• RVB0D 13 • RVB30 17

Correction Policy Change

- Effective May 19, 2013, a Modification may now be used for errors in the following items:
  - A0310: Type of Assessment; **where there is no Item Set Code (ISC) change.**
  - A1600: Entry Date
  - A2000: Discharge Date
  - A2300: Assessment Reference Date (ARD)

Correction Policy Changes

Example 1: Modification of Assessment Type

A0310A = 99; None of the above
A0310B = 03; 30-day scheduled assessment
A0310C = 04; Change of Therapy OMRA (COT)

Q: If A0310C should have been coded as "00" (standalone 30-day assessment), can this assessment be corrected through modification?

A: Yes, as the ISC used for the modified assessment (NP) is the same as the ISC used for the previously accepted assessment.

Correction Policy Changes

Example 2: Modification of Assessment Type

A0310A = 99; None of the above
A0310B = 07; Unscheduled assessment used for PPS A0310C = 04; COT

- **Q: If A0310B should have been coded as "03" (30-day/COT combined), can this assessment be corrected through modification?**
- **A: No, as the ISC used for the modified assessment (NP) is the different from the ISC used for the previously accepted assessment (NO).**

Correction Policy Changes

Example 2: Modification of Assessment Type

A0310A = 99; None of the above
A0310B = 07; Unscheduled assessment used for PPS A0310C = 04; COT

- **Q: If A0310B should have been coded as "03" (30-day/COT combined), can this assessment be corrected through modification?**
- **A: No, as the ISC used for the modified assessment (NP) is the different from the ISC used for the previously accepted assessment (NO).**

Correction Policy Changes

Modification of an ARD

If the change would result in a different look-back period than was used to code the previously accepted assessment, then this is not a typographical error.

- Ask yourself: Would altering the ARD result in a change to the assessment timeframe used to code this assessment?
- Yes; Inactivate the assessment. No; Modify the assessment.

Provider Liability Vs Default Billing

- Provider Liability
  - No payment from Medicare program. Occurs when a required assessment was not completed. Those days associated with that assessment are considered provider liable.
- Default Billing
  - Lowest Medicare payment for the facility (equal to PA1 rate). Occurs when an assessment is completed late or early, not in compliance with ARD requirements.

Provider Liability

Provider Liability

The SNF must bill a covered bill using Occurrence Span Code 77 indicating the facility is liable for the services.

The sum of all covered units reported on all revenue code 0022 lines should be equal to the covered days field less the number of provider liable days reported in the occurrence span code 77

ARD Selections

- **Early Scheduled Assessments**
  - An assessment must be completed according to the designated Medicare PPS assessment schedule. If a scheduled Medicare required assessment is performed earlier than the schedule indicates (based on ARD), the provider will be paid at the default rate for the number of days the assessment was out of compliance.

ARD Selections

- **Late Scheduled Assessments**
  - If the SNF fails to set the ARD within the defined ARD window for a scheduled Medicare required assessment (or OMRA), the ARD can be no earlier than the day the omission was identified.

Early COT Assessments

- If the ARD for a COT OMRA is set for a date prior to day 7 of the COT observation period, the facility must bill the default rate for the total number of days the assessment is out of compliance (# of days early).
- Default rate would be effective from day 1 of the COT observation period and is billed for the number of days the COT was early.
- COT schedule is impacted.

Early COT Assessments - Example

- 14-day assessment ARD is Day 14
- COT Observation period are Days 15 – 21
- COT ARD is set for Day 20. 1 Day Early!
- Default would be billed for Day 14.
- COT RUG would be billed for Days 15 until next scheduled or unscheduled assessment is in effect.
- **Early COT will reset COT schedule. Next COT date = Day 27.**

Late 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 is STILL on Part A, the ARD cannot be set for any earlier than the day the omission was identified.

Late Unscheduled Assessment

- The total number of days the unscheduled assessment is out of compliance, including the ARD, must be billed at the default rate, beginning on the day that the assessment would have been effective.

Ronald A Orth, RN, NHA, RAC-MT
Chief Clinical Officer
rorth@aissystems.com

@RonOrthAIS

Part A –UB-04 Triple Check Form

Resident Name: _____ Facility: _____
Dates of Service: From _____Through _____ Billing Month/Year: _____

Business Office, Nursing and Rehab to assess: place a (√) check in the first column when the standard is met. (X) for NOT MET

MET	COMPLIANCE STANDARD	SOURCE
	1. Beneficiary's name correct per CWF Screen	Common Working File
	2. Birthday correct per CWF screen	Common Working File
	3. Sex correct per CWF	Common Working File
	4. Status Correct	
	5. "Total" is present	**UB04**
	6. Provider number is correct	
	7. Beneficiary's Medicare number is correct per CWF	Common Working File
	8. NPI number and doctor's name is correct	**UB04**
	9. Remarks for processing claim are present, if applicable	**UB04**

Business Office, Nursing and Rehab to assess: place a (√) check in the first column when the standard is met. (X) for NOT MET

MET	COMPLIANCE STANDARD	SOURCE
	10. Bill type is correct	UB-04
	11. Dates of Service are correct	Medicare/PPS Scheduler Report
	12. Admission date is correct	Admission Face Sheet
	13. Qualifying hospital stay is correct	Admission Face Sheet
	14. All needed condition, occurrence and value codes are present/correct, including date skilled coverage ended, if applicable.	UB-04
	15. RUGs & HIPPS codes agree with Medicare/PPS Scheduler Report	Medicare/PPS Scheduler Report
	16. PPS Assessments have been submitted and accepted	MDS Validation Report
	17. For Rehab RUG, PT, OT, ST charges are present and Correct. ***Rehabilitation minutes accurate & consistent***	Rehab Services Grid
	18. Significant changes and or OMRAs are billed correctly	Medicare/PPS Scheduler Report
	19. ARDs agrees with Medicare/PPS Scheduler Report	Medicare/PPS Scheduler Report
	20. ARD falls within required timeframe	Medicare/PPS Scheduler Report
	21 Number of days billed for each assessment type are Correct	Medicare/PPS Scheduler Report
	22. Pharmacy charges are appropriate and accurate	Pharmacy Invoice
	23. Med supply charges are appropriate and accurate.	Supply invoices
	24. Therapy charges are appropriate and accurate (# of days, charges)	Therapy Billing Log
	25. Diagnoses are updated, current	UB 04
	26. Rehab medical and treatment DX are present and Correct	UB04
	27. Therapy orders are signed and current.	Physician Orders
	28. Cert/recert form is completed, ***signed and dated*** by Physician (or NPP)	Progress notes / Cert-Recert form
	29. Rehab Orders / Plan of Care / Updated plan of care are signed and dated by the physician	Medical record

_____ **Administrator** _____Date
_____ **BOM** _____Date
_____ **MDS Coordinator** _____Date
_____ **Rehab** _____Date

WPS MEDICARE SNF PPS MDS 3.0 PAYMENT SCHEDULER

Assessment Indicators	Type of Assessment	ARD Days	Grace Days	Payment Days Start	Payment Days End
Standard PPS Assessment (not combined with any other assessment)					
10	PPS 5 day or readmission	1-5	6-8	1	14
20	PPS 14 day	13-14	15-18	15	30
30	PPS 30 day	27-29	30-33	31	60
40	PPS 60 day	57-59	60-63	61	90
50	PPS 90 day	87-89	90-93	91	100
SCSA or SCPA Assessment					
SCSA: The ARD must be no later than **14 days** after a significant change is identified. **SCPA:** Required when an uncorrected major error is discovered in a prior comprehensive assessment.					
01	SCSA or SCPA (stand alone)	See above	N/A	The earlier of either the ARD date or the beginning of the standard payment period	End of standard payment period
11	SCSA or SCPA replacing 5 day PPS	1-5	6-8		14
21	SCSA or SCPA replacing 14 day PPS	13-14	15-18		30
31	SCSA or SCPA replacing 30 day PPS	27-29	30-33		60
41	SCSA or SCPA replacing 60 day PPS	57-59	60-63		90
51	SCSA or SCPA replacing 90 day PPS	87-89	90-93		100
Start of Therapy (SOT) OMRA (Z0100A must be a therapy RUG or assessment is invalid)					
SOT OMRA is an **optional** assessment. If done, the ARD must be on day **5, 6, or 7** after the start of therapy.					
02	SOT OMRA (stand alone)	See above	N/A	The first day of therapy	End of standard payment period
12	SOT OMRA & 5 day PPS	1-5	6-8		14
22	SOT OMRA & 14 day PPS	13-14	15-18		30
32	SOT OMRA & 30 day PPS	27-29	30-33		60
42	SOT OMRA & 60 day PPS	57-59	60-63		90
52	SOT OMRA & 90 day PPS	87-89	90-93		100
SOT OMRA and SCSA or SCPA (Z0100A must be a therapy RUG or assessment is invalid)					
SCSA: The ARD must be no later than **14 days** after a significant change is identified. **SCPA:** Required when an uncorrected major error is discovered in a prior comprehensive assessment. **SOT OMRA** is an **optional** assessment. If done, the ARD must be on day **5, 6, or 7** after the start of therapy.					
03	SOT OMRA combined with a SCSA/SCPA	See above	N/A	The first day of therapy	End of standard payment period
13	SOT OMRA, SCSA/SCPA & 5 day PPS	1-5	6-8		14
23	SOT OMRA, SCSA/SCPA & 14 day PPS	13-14	15-18		30
33	SOT OMRA, SCSA/SCPA & 30 day PPS	27-29	30-33		60
43	SOT OMRA, SCSA/SCPA & 60 day PPS	57-59	60-63		90
53	SOT OMRA, SCSA/SCPA & 90 day PPS	87-89	90-93		100

Assessment Indicators	Type of Assessment	ARD Days	Grace Days	Payment Days
End of Therapy (EOT) OMRA (with or without an SCSA/SCPA)				
EOT OMRA is **required** when all therapies are discontinued and a skilled level of care remains. The EOT OMRA ARD must be set on day **1, 2, or 3** after all rehabilitation therapies have been discontinued.				
04	EOT OMRA	See above	N/A	Use Z0150A (non-therapy RUG) from the day after the last day of therapy thru the end of the standard payment period (day 14, 30, 60, 90 or 100)
14	EOT OMRA & 5 day PPS	1-5	6-8	
24	EOT OMRA & 14 day PPS	13-14	15-18	
34	EOT OMRA & 30 day PPS	27-29	30-33	
44	EOT OMRA & 60 day PPS	57-59	60-63	
54	EOT OMRA & 90 day PPS	87-89	90-93	
SOT OMRA and an EOT OMRA (Z0100A must be a therapy RUG or assessment is invalid)				
SOT OMRA is an **optional** assessment. If done, the ARD must be on day **5, 6, or 7** after the start of therapy. **EOT OMRA ARD** must be set on day **1, 2, or 3** after all rehabilitation therapies have been discontinued.				
05	SOT OMRA with EOT OMRA (stand alone)	See above	N/A	Z0100A pays from first day of therapy thru last day of therapy and then Z0150A pays thru the end of the standard payment period (day 14, 30, 60, 90 or 100)
15	SOT OMRA, EOT OMRA & 5 day PPS	1-5	6-8	
25	SOT OMRA, EOT OMRA & 14 day PPS	13-14	15-18	
35	SOT OMRA, EOT OMRA & 30 day PPS	27-29	30-33	
45	SOT OMRA, EOT OMRA & 60 day PPS	57-59	60-63	
55	SOT OMRA, EOT OMRA & 90 day PPS	87-89	90-93	
SOT OMRA, EOT OMRA & SCSA/SCPA (Z0100A must be a therapy RUG or assessment is invalid)				
SOT OMRA is an **optional** assessment. If done, the ARD must be on day **5, 6, or 7** after the start of therapy. **EOT OMRA ARD** must be set on day **1, 2, or 3** after all rehabilitation therapies have been discontinued. **SCSA:** The ARD must be no later than **14 days** after a significant change is identified. **SCPA:** Required when an uncorrected major error is discovered in a prior comprehensive assessment.				
06	SOT OMRA, EOT OMRA & SCSA/SCPA	See above	N/A	Z0100A pays from first day of therapy thru last day of therapy and then Z0150A pays thru the end of the standard payment period (day 14, 30, 60, 90 or 100)
16	SOT, EOT, SCSA/SCPA & 5 day PPS	1-5	6-8	
26	SOT, EOT, SCSA/SCPA & 14 day PPS	13-14	15-18	
36	SOT, EOT, SCSA/SCPA & 30 day PPS	27-29	30-33	
46	SOT, EOT, SCSA/SCPA & 60 day PPS	57-59	60-63	
56	SOT, EOT, SCSA/SCPA & 90 day PPS	87-89	90-93	
Medicare Short Stay Assessment				
07	Short Stay (stand alone)	Last day of the part A stay		See CMS's RAI Version 3.0 Manual, Chapter 6, Pages 6-15
17	Short Stay combined with 5 day PPS			
End of Therapy Reporting Resumption (EOT-R) OMRA				
EOT-R OMRA ARD must be set on day **1, 2, or 3** after all rehabilitation therapies have been discontinued. Therapies must resume within 5 calendar days.				
0A	SOT OMRA with EOT OMRA (stand alone)	See above	N/A	Z0150A pays from the day after the last day of therapy the day before the resumption of therapy date. Z0100A from the assessment immediately preceding this EOT-R thru the end of the standard payment period.
1A	SOT OMRA, EOT OMRA & 5 day PPS	1-5	6-8	
2A	SOT OMRA, EOT OMRA & 14 day PPS	13-14	15-18	
3A	SOT OMRA, EOT OMRA & 30 day PPS	27-29	30-33	
4A	SOT OMRA, EOT OMRA & 60 day PPS	57-59	60-63	
5A	SOT OMRA, EOT OMRA & 90 day PPS	87-89	90-93	

Assessment Indicators	Type of Assessment	ARD Days	Grace Days	Payment Days

Change of Therapy (COT) OMRA					
COT OMRA is required when the COT observation period indicates there is a change in therapy intensity that results in a new RUG category. The ARD is set on the last day of the COT observation period.					
0D	COT OMRA (stand alone)	See above	N/A	The first day of the COT observation period	End of standard payment period
1D	COT OMRA & 5 day PPS	N/A	N/A		N/A
2D	COT OMRA & 14 day PPS	13-14	15-18		30
3D	COT OMRA & 30 day PPS	27-29	30-33		60
4D	COT OMRA & 60 day PPS	57-59	60-63		90
5D	COT OMRA & 90 day PPS	87-89	90-93		100

Default Rate (AAAxx) for assessments that fail to comply with the assessment schedule.

- **Early assessments**: If an assessment is performed earlier than the schedule indicates, the provider will be paid at the default rate for the number of days the assessment was out of compliance (e.g. 14 day assessment with ARD done on day 10, 1 day early, would be paid at default for the first day of the payment period that begins on day 15). Use the AI associated with the early assessment with RUG AAA for days paid at default. (e.g. AAA20 for early 14 day PPS)
- **Late assessments**:
  - If an assessment is performed after the grace period, payment will be made at the default rate from the first day of the coverage period to the ARD of the late assessment (e.g. 14 day assessment with ARD done on day 22, days 15-21 paid at default). Use the AI associated with the late assessment with RUG AAA for days paid at default. (e.g. AAA30 for a late 30 day PPS)
  - 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 SNF must bill all covered days at default.
- **Missed assessments:** No MDS assessment in QIES ASAP. Can bill AAA00 only when exception requirements listed in Chapter 6 of the RAI 3.0 are met.

Abbreviations

AI = Assessment Indicator
ARD = Assessment Reference Date
COT = Change of Therapy
EOT = End of Therapy
EOT-R = End of Therapy Reporting Resumption
OBRA = Omnibus Budget Reconciliation Act
OMRA = Other Medicare-required Assessment
SOT = Start of Therapy
SCSA = Significant Change in Status Assessment
SCPA = Significant Correction to Prior Comprehensive Assessment