Skilled Nursing Facility (SNF) MDS Assessment Schedule

Teleconference
October 20, 2011

Presented by:
Janet Mateo
Agenda

• Overview Of Minimum Data Set (MDS) Assessments

• FY 2012 Changes
  – Revisions to the MDS Assessment Schedule
  – Modification to EOT OMRA
  – New PPS Assessment
Agenda

- Billing SNF MDS Assessments
- SNF Notices of Non-Coverage Clarification
- Non-compliance with the MDS Assessment Schedule
- Importance of Communication Among SNF staff
Overview Of Minimum Data Set (MDS) Assessments
Minimum Data Set (MDS)

- Completed for all residents in Medicare- or Medicaid-certified nursing homes

- Forms foundation of a comprehensive assessment
Minimum Data Set (MDS)

• Used to calculate the RUG-IV classification necessary for payment

• Contains extensive information on resident’s
  – Nursing needs
  – Activities of Daily Living (ADL) impairments
  – Cognitive status
  – Behavioral problems
  – Medical diagnoses
OBRA Required Assessments

- Omnibus Budget Reconciliation Act (OBRA) regulations require nursing homes to conduct initial and periodic assessments

- Federally mandated for all residents of Medicare and/or Medicaid certified nursing homes
  - Regardless of age, diagnosis, length of stay, or payment category
OBRA Required Assessments

- Entry record
- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- Significant Change in Status Assessments (SCSA) (comprehensive)
OBRA Required Assessments

• Significant Correction to a Prior Medicare Required Assessment (SCPA) (comprehensive)

• Significant Correction to Prior Quarterly Assessment (SCQA)

• Discharge reporting
  – Discharge assessments
  – Death in facility record
Medicare Required PPS Assessments

- Requirements for OBRA assessments apply
- Determine Medicare Part A payment
- Provides information about the clinical condition of beneficiaries receiving Part A SNF-level care
Medicare Required PPS Assessments

- 5-day
- 14-day
- 30-day
- 60-day
- 90-day
Medicare Required PPS Assessments

- Readmission/Return
- SCSA
- SCPA
- Swing Bed Clinical Change (CCA)
Medicare Required PPS Assessments

- Start of Therapy (SOT) Other Medicare Required (OMRA)
- End of Therapy (EOT) OMRA
- End of Therapy Resumption (EOT-R)
- Change of Therapy (COT) OMRA
Combining The Two Assessments

• When OBRA and Medicare PPS assessment time frames coincide
  – One assessment may be used to satisfy both requirements
  – Most stringent requirement for MDS completion must be met
Timing Of Medicare Required PPS Assessments
Regular Timing Of Medicare Assessments

• The assessment schedule begins
  – Day 1 of Medicare Part A coverage
Changes For Fiscal Year 2012

• Revisions to MDS Assessment Schedule
  – ARD window narrowed
  – Grace days window narrowed

• New PPS Assessment
  – Change of Therapy (COT) OMRA
Changes For Fiscal Year 2012

• EOT OMRA Modified into EOT Resumption

• Revised SNF EOT OMRA Policy
  – All facilities considered 7-day facilities
## FY 2011 Assessment Schedule (Prior To 10/01/2011)

<table>
<thead>
<tr>
<th>Assessment Indicators</th>
<th>Type of Assessment</th>
<th>ARD Days</th>
<th>Grace Days</th>
<th>Payment Days</th>
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</thead>
<tbody>
<tr>
<td>Standard PPS Assessment (not combined with any other assessment)</td>
<td>10</td>
<td>1-5</td>
<td>6-8</td>
<td>1</td>
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<tr>
<td></td>
<td>20</td>
<td>11-14</td>
<td>15-19</td>
<td>15</td>
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<tr>
<td></td>
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<td>21-29</td>
<td>30-34</td>
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<tr>
<td></td>
<td>50</td>
<td>80-89</td>
<td>90-94</td>
<td>91</td>
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</table>
### New Assessment Schedule (Beginning 10/01/2011)

<table>
<thead>
<tr>
<th>Assessment Indicators</th>
<th>Type of Assessment</th>
<th>ARD Days</th>
<th>Grace Days</th>
<th>Payment Days</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard PPS Assessment (not combined with any other assessment)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>10</td>
<td>PPS 5 day or readmission</td>
<td>1-5</td>
<td>6-8</td>
<td>1</td>
<td>1</td>
<td>14</td>
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<tr>
<td>20</td>
<td>PPS 14 day</td>
<td>13-14</td>
<td>15-18</td>
<td>15</td>
<td>15</td>
<td>30</td>
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<tr>
<td>30</td>
<td>PPS 30 day</td>
<td>27-29</td>
<td>30-33</td>
<td>31</td>
<td>31</td>
<td>60</td>
</tr>
<tr>
<td>40</td>
<td>PPS 60 day</td>
<td>57-59</td>
<td>60-63</td>
<td>61</td>
<td>61</td>
<td>90</td>
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<tr>
<td>50</td>
<td>PPS 90 day</td>
<td>87-89</td>
<td>90-93</td>
<td>91</td>
<td>91</td>
<td>100</td>
</tr>
</tbody>
</table>
The MDS Calendar

• Useful tool for MDS coordinators and billing staff

• Download – Legacy Providers
  – [http://www.wpsmedicare.com/parta/resources/provider_types/Skilled Nursing Facility (SNF)/MDS calendar](http://www.wpsmedicare.com/parta/resources/provider_types/Skilled%20Nursing%20Facility%20(SNF)/MDS%20calendar)

• Download – J5 Providers
  – [http://www.wpsmedicare.com/j5macparta/resources/provider_types/Skilled%20Nursing%20Facility%20(SNF)/MDS%20Calendar](http://www.wpsmedicare.com/j5macparta/resources/provider_types/Skilled%20Nursing%20Facility%20(SNF)/MDS%20Calendar)
Setting the Assessment Reference Date (ARD)

• Revised MDS Assessment schedule is required to set the ARD for scheduled PPS assessments beginning in FY 2012
  – New ARD assessment window created

• Applies to all assessments where the ARD falls on or after October 1, 2011.
Grace Days Revised

- The revised MDS Assessment Schedule narrows grace day windows for each assessment
Unscheduled Assessments

• May occur any time during stay when requirements met

• Must now be combined with PPS assessments when ARDs overlap
  – OMRAs may not replace a PPS assessment

• May be combined with each other
  – SCSA & SCPA may NOT be combined
Unscheduled Assessments

- Significant Change in Status Assessments (*SCSA*)
- Start of Therapy (*SOT*) Other Medicare Required Assessments (*OMRA*)
- End of Therapy (*EOT*) OMRA
Unscheduled Assessments

- End of Therapy Resumtion (EOT-R) OMRA
  - New Option

- Change of Therapy (COT) OMRA
  - New PPS Assessment

- Significant Correction to a Prior Medicare Required Assessment (SCPA)
Combining Scheduled & Unscheduled PPS Assessments

• Combine assessments
  – Unscheduled PPS assessment falls within ARD window, and
    • ARD of scheduled assessment not yet set

• ARD of combined assessment
  – Use the same ARD that would have been used for unscheduled assessment
Stand-Alone Unscheduled Assessment

• Bill only when the unscheduled assessment is set outside ARD window, AND
  – The scheduled assessment has already been performed
End Of Therapy (EOT)  
Other Medicare Required Assessment (OMRA)
Revised SNF EOT OMRA Policy
“Three Day” Policy

• EOT OMRA must be completed
  – Beneficiary classified in any RUG-IV rehab group
  – Therapy not received for 3 or more calendar days

• ARD for EOT OMRA
  – Must be set for Day 1, 2, or 3 after last therapy session
SNF Notices of Non-Coverage Clarification

• SNF Notices of Non-Coverage not required
  – When a beneficiary misses 3 consecutive days of therapy

• Timing of the SNF ABN delivery remains unchanged

• Expedited Determination Notice Policy has not changed
End Of Therapy With Resumption (EOT-R)
EOT With Resumption (EOT-R)

• Effective 10/01/2011

• Criteria:
  – Same therapy level
  – $\leq 5$ days after last day of therapy

• Not a new PPS assessment
  – Modify prior EOT OMRA
Modifying EOT Into EOT-R

- EOT has **not** been accepted in QIES ASAP
  - Complete O0450A and O0450B on EOT OMRA
  - Submit combined EOT/EOT-R

- EOT (without EOT-R items) **has** been accepted in QIES Assessment Submission and Processing (ASAP) system
  - Submit modification request
    - Only change O0450A and O0450B, and check X0900E
Change Of Therapy (COT) OMRA
COT OMRA

~NEW PPS ASSESSMENT~

• Effective for ARDs after 10/01/2011

• Required if therapy received during the COT observation period causes the patient to be classified into a different RUG category.

• COT observation period
  – Successive 7-day window
Non-Compliance With The SNF PPS Assessment Schedule
Early Assessments

• Scheduled Medicare required assessment or OMRA performed before schedule indicates (ARD not in the defined window)
  – Bill the default code (AAAxx)
    • For the number of days the assessment was out of compliance
      – Starting with the first day of payment period
    • xx = AI that would be used for related assessment
Late Assessments

• ARD may not be before the date the omission of assessment is identified

• ARD set prior to end of payment period
  – Bill default rate up to day before ARD
    • Bill the default code (AAAxx)
  – Bill Health Insurance Prospective Payment System (HIPPS) rate ARD to end of regular payment period
Late Assessments

• ARD set after payment period and stay is still covered
  – Default rate for related payment period
    • Bill the default code (AAAxx)

• **Cannot** be used to replace next regularly scheduled Medicare required assessment
Missed Assessments

• Beneficiary is no longer on Part A
  – Not able to complete an assessment which would cover days
  – ARD would be after SNF coverage ended
  – No payment may be made, provider liable
    • Bill default rate AAA00
    • Occurrence span code 77
Missed Assessments

• May bill default code if:
  1. Stay is less than 8 days within a spell of illness
     – Short Stay Policy may apply
  2. SNF is notified untimely of, or unaware of, a Medicare Secondary Payer denial
Missed Assessments

• May bill default code if:
  3. SNF is notified untimely of revocation of payment ban
  4. Beneficiary requests demand bill
  5. SNF is notified untimely of, or unaware of, a beneficiary’s disenrollment from a Medicare Advantage plan
Missed Assessments

• AAA00 may be used when:
  – No PPS (or OBRA) assessment done
    • Due to one of previously mentioned 5 situations
  – Benefits have exhausted
  – Non-skilled “no-pay” claims
  – Medicare Advantage information only claims
  – Same day transfers
Missed Assessments

• AAA60 may be used when:
  – OBRA assessment done, but Part A eligibility unknown at time of assessment
    • Due to one of previously mentioned situations 2 through 5
      – May not be used for Short Stay assessment
Medicare Short Stay Policy
Short Stay Policy

• Beneficiary may be eligible for short stay policy, if on or before the eighth day of a covered SNF stay the beneficiary:
  – Dies
  – Discharged from the SNF
  – Discharged from Part A level of care
Short Stay Policy

- Allows assignment into a Rehabilitative Plus Extensive Services or Rehabilitative category
  - When beneficiary received rehabilitative therapy and was not able to receive 5 days of therapy due to discharge from Medicare Part A

- To be considered a Medicare Short Stay
  - All 8 requirements must be met
8 Medicare Short Stay Assessment Requirements

- Assessment Requirements
  1. Must be SOT OMRA
  2. 5-day or readmission/return assessment must be completed
    - May be combined with the SOT OMRA
8 Medicare Short Stay Assessment Requirements

• ARD Requirements

  3. Must be Day 8 or earlier of Part A stay
  4. Must be last day of Part A stay
  5. Must be more than 3 days after the start of therapy
8 Medicare Short Stay Assessment Requirements

- Rehabilitation Requirements
  
  6. Must have started in last 4 days of Part A stay
     - Including weekends
  
  7. Must continue through last day of Part A stay
8 Medicare Short Stay Assessment Requirements

• RUG Requirement

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

All 8 requirements must be met!
MDS Assessments & Billing Medicare
Prior To Billing Medicare

- All assessments must be transmitted to the State RAI Database prior to billing.
- Check MDS Final Validation Report prior to billing the FI/A/B MAC.
- The covered days must have been used.
- Claim will be denied upon medical review if MDS is not in the repository.
Reporting HIPPS Code(s) On Claim

• Revenue code = 0022

• Health Insurance Prospective Payment System (HIPPS) Rate Code
  – RUG Code + Assessment Indicator (AI)

• Service date = ARD
  – **Effective January 1, 2011:** ARD reported with occurrence code 50
Reporting HIPPS Code(s) On Claim

• Service units = # of days being billed under HIPPS code
• Total charges = $0.00

**Each HIPPS code needs to be reported separately**
## Example: Admit Date 11/16/11

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Assessment Date</th>
<th>Days Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-day Assessment</td>
<td>11/20/11</td>
<td>11/16/11 – 11/29/11</td>
</tr>
<tr>
<td>14-day Assessment</td>
<td>12/28/11</td>
<td>11/30/11 – 12/14/11</td>
</tr>
<tr>
<td>30-day Assessment</td>
<td>01/12/12</td>
<td>12/16/11 – 12/14/12</td>
</tr>
</tbody>
</table>
Unscheduled Assessments – Payment & Billing

• SCSA, SCPA, and Swing Bed CCA assessments
  – Begin modifying the payment rate on the ARD
  – Except when ARD is a grace day
Unscheduled Assessments – Payment & Billing

• SOT OMRA
  – RUG takes effect day therapy started

• EOT OMRA
  – RUG takes effect day after the last day of therapy provided
Unscheduled Assessments – Payment & Billing

• EOT-R OMRA
  – RUG takes effect on the last therapy date through the day before the resumption of therapy date

• COT OMRA
  – RUG takes effect on day 1 of the COT observation period
Billing For Breaks In Therapy

~Non-therapy RUG
– From day after therapy ends through day before resumption

• RUG from prior PPS assessment
  – From day of resumption to end of payment period
Transition to FY 2012 Billing

• If the billing period splits between fiscal years, payment needs to be established for the entire period
  – FY RUG-IV and FY 12 RUG-IV Groups
RUGs & Therapy

- **RUA, RUB, RUC, RUL, RUX**
  - Minimum of 2 rehabilitation therapy ancillary codes are required
    - Rev code 042x and/or, 043x and/or, 044x

- **RHA, RHB, RHC, RHL, RHX, RLA, RLB, RLX, RMA, RMB, RMC, RML, RMX, RVA, RVB, RVC, RVL, RVX**
  - Minimum of 1 rehabilitation therapy ancillary code is required
    - Rev code 042x and/or, 043x and/or, 044x
Communication
Departmental Responsibilities

• Admitting Office
  – Resident’s available Part A days

• Clinical Staff
  – RUG-IV code, assessment reference date, and type of assessment to billing staff
Departmental Responsibilities

• Therapy/Service Staff
  – Report types of services and number of units to billing staff

• Billing Staff
  – Correctly bill the resident’s Part A stay
Summary

- FY 2012 MDS Assessment Changes
- Clarification of SNF Notices of Non-Coverage
- Non-compliance with SNF PPS Schedule
- Transition Billing
References

• MDS Calendar/Payment Scheduler
  – Legacy Providers
    • http://www.wpsmedicare.com/part_a/resources/provider_types/
  – J5 Providers
    • http://wpsmedicare.com/j5macparta/resources/provider_types/index.shtml

• MDS Version 3.0
References

• Billing SNF PPS Services
  – CMS IOM; Publication 100-04, Medicare Claims Processing Manual; Chapter 6; Section 30

• Proper Use of HIPPS Code AAA00
  – Federal Register / Vol. 73, No. 154 / Friday, August 8, 2008
    • http://edocket.access.gpo.gov/2008/pdf/E8-17948.pdf
Additional Information
WPS Medicare eNews!
Your Most Up-to-Date Medicare Resource

Sign up by:

1. Going to wpsmedicare.com & click on eNews

2. Contacting today’s presenter
www.wpsmedicare.com

• Resources available on website:
  – Frequently asked questions (FAQs)
  – Claims submission errors
  – Live training
  – Publications
  – Provider specialty/services
  – Forms
  – Surveys
  – Contact us
## Provider Contact Centers

<table>
<thead>
<tr>
<th>Region</th>
<th>Contact Number</th>
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</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>(866) 580-5981</td>
</tr>
<tr>
<td>Northeast</td>
<td>(866) 580-5945</td>
</tr>
<tr>
<td>Central</td>
<td>(866) 580-5984</td>
</tr>
<tr>
<td>West</td>
<td>(866) 580-5987</td>
</tr>
<tr>
<td>J5</td>
<td>(866) 518-3285</td>
</tr>
</tbody>
</table>
Let Your Voice Shape The WPS Medicare Website

• ForeSee Survey
  – Gauges provider satisfaction with WPS Medicare website
    • Conducted by ForeSee Results

• Departmental Surveys
  – Determines whether each section of the website meets provider needs
CMS Website

- Resources available:
  - Internet-Only Manuals (IOMs)
    - http://www.cms.gov/Manuals/IOM/list.asp
  - Transmittals
  - MLNs
  - Quarterly Provider Updates (QPU)
Remittance Advice Information

• Web-Based Training (WBT) on Remittance Advice (RA) now available

• Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs)
  – http://www.wpc-edi.com/codes
  – DDE, menu options 16 and 68

• Electronic Remittance Advice (ERA) saves time and money
MCPSS

- Medicare Contractor Provider Satisfaction Survey (MCPSS)
- Measures level of satisfaction providers and suppliers experience with contractor-provider relationship
- Distributed annually to random sample of Medicare FFS providers and suppliers
  - Provider/Supplier participation in the survey is voluntary
5010

• January 1, 2012
  – All EDI users must start sending claims in 5010 format

• Vendor and/or Clearinghouse users
  – Contact Vendor and/or Clearinghouse regarding their plans for transitioning to the 5010 format

• PC-Ace Pro-32 users
  – Always use most up-to-date version
5010

• For more information:
  – http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
ICD-10

• October 1, 2013
  – Implementation of ICD-10-CM (diagnoses) and ICD-10-PCS (procedures)

• Provides significant improvements through greater detailed information

• For more information:
  – http://www.cms.gov/ICD10
This program is presented for informational purposes only.

Current Medicare regulations will always prevail.
Questions?