6.8 Non-compliance with the SNF PPS Assessment Schedule

To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as described in Chapter 2.

According to 42 CFR 413.343, an assessment that does not have an ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent late assessment scheduling practices or missing assessments may result in additional review. The default rate (ZZZZZ) takes the place of the otherwise applicable Federal rate. It is equal to the sum of the rate paid for the case-mix group reflecting the lowest acuity level under each PDPM component, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Late Assessment

If the SNF fails to set the ARD within the defined ARD window for a PPS assessment, 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.

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 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 5-Day assessment with an ARD of Day 11 is out of compliance for 3 days and therefore would be paid at the default rate for Days 1 through 3 and the HIPPS code from the late 5-Day assessment for the remainder of the Part A stay, unless an IPA is completed. In the case of a late assessment, the variable per diem schedule still begins on Day 1 of the stay and not with the late assessment ARD and default billing will be assessed prior to billing based on the late 5-Day assessment.

Missed Assessment

If the SNF fails to set the ARD of a PPS assessment prior to the end of the last day of the ARD window, and the resident is no longer a SNF Part A resident, and as a result a PPS assessment does not exist in *i*QIES for the payment period, the provider may not usually bill for days when an assessment does not exist in *i*QIES. When a PPS assessment does not exist in *i*QIES, there is not a HIPPS code the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid PPS assessment that is accepted into *i*QIES. The provider must bill the HIPPS code that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, a PPS assessment may not be performed.

However, there are instances when the SNF may bill the default code when a PPS assessment does not exist in *i*QIES. These exceptions are:

1. The stay is less than 8 days within a spell of illness,
2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

ARD Outside the Medicare Part A SNF Benefit

A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a PPS assessment. For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in *their* SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the HIPPS code associated with the assessment.

APPENDIX A: GLOSSARY AND COMMON ACRONYMS

Glossary

Term	Abbreviation	Definition
Ability to Understand Others		Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the resident's ability to process and understand language.
Active Assisted Range of Motion		A type of active range of motion in which assistance is provided by an outside force, either manually or mechanically because the prime mover muscles need assistance to complete the motion. This type of range of motion may be used when muscles are weak or when joint movement causes discomfort; or for example, if the resident is able to move *their* limbs but requires help to perform entire movement.
Active Discharge Plan		*An **active** discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge, and there is a target discharge date for the near future. If there is not an **active** discharge plan, residents should be asked if they want to talk to someone about community living and then referred to the Local Contact Agency (LCA) accordingly. Furthermore, referrals to the LCA are recommended as part of many residents' discharge plans. Such referrals are a helpful source of information for residents and facilities in informing the discharge planning process.*
Active Disease Diagnosis		An illness or condition that is currently causing or contributing to a resident's complications and/or functional, cognitive, medical and psychiatric symptoms or impairments.
Active Range of Motion		Movement within the unrestricted range of motion for a segment, which is produced by active contraction of the muscles crossing that joint is completed without assistance by the resident. This type of range of motion occurs when a resident can move *their* limbs without assistance.