

AOTA Analysis: Final Skilled Nursing Facility PPS Rule for FY 2012

The Centers for Medicare & Medicaid Services (CMS) published the [Skilled Nursing Facility \(SNF\) Prospective Payment System \(PPS\) final rule for fiscal year 2012](#) in the August 8, 2011, *Federal Register*. The final rule addresses 2012 SNF payment rates, as well as student supervision, group therapy coverage and documentation requirements, the Minimum Data Set Version 3.0 (MDS 3.0) assessment schedule, and Other Medicare-Required Assessments (OMRAs). Rate changes and policy revisions will go into effect October 1, 2011.

AOTA was invited to participate in a limited briefing with CMS officials when the rule was announced on July 29, 2011. The briefing indicated that the rule was essentially adopted as proposed, which may have negative consequences for the SNF industry. AOTA also organized and participated in a CMS briefing for the professional therapy associations. AOTA will update members as we work with CMS and SNF industry members preparing for implementation of the new rule, including providing CMS with ideas for topics for a Medicare Learning Network (MLN) Matters article to help providers understand provisions in the final rule.

AOTA will continue to analyze the new policies to monitor their impact and guide our ongoing advocacy efforts. Please e-mail rpd@aota.org to let us know how you are implementing the new requirements and what issues you are facing as a result of the regulation. We will prepare additional materials as needed.

SNF PPS Rates

CMS is reducing Medicare SNF PPS payments in FY 2012 by \$3.87 billion, which means that FY 2012 payments will be 11.1% lower than payments for FY 2011. CMS reports that the FY 2012 rates are intended to correct for an unintended spike in payment levels that resulted from the implementation of RUG-IV and the FY 2011 parity adjustment.

CMS is now recalibrating the case-mix indexes (CMIs) for FY 2012 to restore overall payments to their intended levels on a prospective basis. The SNF PPS uses a resource classification system known as Resource Utilization Groups Version 4 (RUG-IV), which assigns a patient to a RUG group to determine a daily payment rate. Each RUG group consists of CMIs that reflects a patient's severity of illness and the services that a patient requires in the SNF. In transitioning from the previous classification system to the new RUG-IV, CMS adjusted the CMIs for FY 2011 based on forecasted utilization under this new classification system to establish parity in overall payments. SNFs have been paid under RUG-IV since Oct. 1, 2010.

CMS found that the parity adjustment made in FY 2011, which was intended to ensure that the new RUG-IV system would not change overall spending levels from the prior

year, instead resulted in a significant increase in Medicare expenditures during FY 2011. CMS determined that this increase in spending was primarily due to shifts in the utilization of therapy modes under the new classification system differing significantly from the projections on which the original parity adjustment was based. CMS stated that additional data analyzed by CMS since publication of the proposed rule confirmed the extent of the overpayments that have occurred since implementation of the RUG-IV system. The Office of the Inspector General (OIG) validated the increased expenditure levels in a separate review of SNF payments during the first 6 months of FY 2011. Because these levels were determined to result from changes in therapy utilization, CMS applied the parity adjustment to the nursing CMI for the RUG-IV therapy groups and not for the non-therapy groups.

The FY 2012 recalibration of the CMI will result in a reduction to skilled nursing facility payments of \$4.47 billion or 12.6%. However, this reduction will be partially offset by the FY 2012 update to Medicare payments to SNFs. The update—an increase of 1.7% or \$600 million for FY 2012—reflects a 2.7% increase in the prices of a “market basket” of goods and services reduced by a 1% multi-factor productivity (MFP) adjustment mandated by the Affordable Care Act. The combined MFP-adjusted market basket increase and the FY 2012 recalibration will yield a net reduction of \$3.87 billion, or 11.1%.

For FY 2012, CMS reports that the recalibration will reflect the intent of the new RUG-IV system to pay SNF providers more accurately based on the service needs of Medicare beneficiaries in their care. The adjustment was determined using claims and assessment data from the first 8 months of FY 2011. It will ensure that payments more accurately reflect the resources required to provide care for the range of SNF patients, including those requiring more medically complex care.

CMS emphasized that this recalibration removes an unintended spike in payments that occurred in FY 2011 rather than decreasing an otherwise appropriate payment amount. Even with the recalibration, the FY 2012 payment rates will be 3.4% higher than the rates established for FY 2010, the period immediately preceding the unintended spike in payment levels. Further, CMS has not proposed any action to recoup retroactively the excess expenditures already made to SNFs during FY 2011. Instead, CMS limited the scope of the recalibration to restoring the intended SNF PPS payment levels on a prospective basis only, effective October 1, 2011.

In the preamble to the final rule, CMS addressed concerns raised by commenters regarding the loss of jobs as a result of the payment changes. CMS stated that since data does not indicate that facilities increased staffing with the implementation of RUG-IV and aggregate payments will return to a level commensurate with those made under RUG-III, CMS does not believe that restoring payment to their intended and appropriate levels should necessarily result in job losses or add significant burden to health care workers or states.

In addition, CMS addressed concerns that applying the recalibration along with other policy changes such as allocation of group therapy and changes to the MDS 3.0 would result in a “double hit” on facilities. CMS responded that due to the ability of facilities and stakeholders to adapt quickly to the changes in the SNF system in ways that maintain payments and consistent utilization patterns, CMS does not believe it would be appropriate to attempt to consider the potential impact of other policy changes for FY 2012 as part of the FY 2011 recalibration calculation. CMS also rejected the idea of phasing in a recalibration because it would continue to reimburse facilities at levels that significantly exceed intended SNF payments.

CMS also responded to comments recommending greater fraud and abuse monitoring. CMS stated that it has increased fraud and abuse monitoring efforts for SNFs and for the Medicare program in general. Further, the OIG has started a review of the increased frequency with which patients are assigned to the highest therapy groups. CMS will continue to work with OIG and with CMS contractors to provide greater monitoring of SNF utilization and reporting trends.

Student Supervision

CMS finalized its proposal to remove the line-of-sight supervision requirement for students to make it consistent with other inpatient settings. In other inpatient settings, CMS does not specify supervision requirements. In those other settings, supervision is guided by state and local laws and regulations, and the facility itself determines the level of supervision a student needs. CMS stated:

Therefore, for the reasons outlined in this final rule and in the FY 2012 proposed rule (76 FR 26385 through 26386), we are finalizing our proposed revision to the line-of-sight supervision requirements as they pertain to students in a SNF setting. Accordingly, in this final rule, we are hereby discontinuing the policy announced in the FY 2000 final rule’s preamble requiring line-of-sight supervision of therapy students in SNFs, as set forth in the FY 2012 proposed rule. Instead, effective October 1, 2011, as with other inpatient settings, each SNF will determine for itself the appropriate manner of supervision of therapy students consistent with state and local laws and practice standards.

We will be monitoring student participation in SNFs and expect that facilities will ensure that students, though no longer required to be under line-of-sight supervision, will still be properly supervised for both the student’s and patient’s benefit.

In the final rule, CMS referenced detailed supervision guidelines provided by trade associations. CMS recognized the guidelines as playing a significant role in helping to define the applicable standards of practice on which providers rely in this context. CMS posted the guidelines, including the recommended from AOTA, on its Web site. Members may access this [new resource from AOTA](#) which details student supervision requirements across Medicare settings, include the new rules for SNFs.

CMS' current student supervision requirements are included in the RAI Manual for the Minimum Data Set, Version 3.0 (MDS 3.0). See www.aota.org/News/AdvocacyNews/SNF-Students.aspx?FT=.pdf for the current requirements. CMS confirmed that the proposed change to student supervision would require CMS to revise the RAI Manual. AOTA will work with CMS as it revises the RAI Manual.

Group Therapy Policy

CMS finalized its proposals regarding group therapy. Effective October 1, 2011, CMS will define group therapy as therapy provided simultaneously to four patients (regardless of payer source) who are performing the same or similar activities and are supervised by a therapy (or assistant) who is not supervising any other individuals. CMS will allocate group therapy minutes in same manner as concurrent therapy, based on four patients in a group:

We are finalizing our proposed policies related to group therapy effective October 1, 2011. First, we are defining group therapy as therapy provided simultaneously to four patients (regardless of payer source) who are performing the same or similar activities and are supervised by a therapist (or assistant) who is not supervising any other individuals (76 FR 26386 through 26387). In addition, we are finalizing our proposed policies related to the reporting and allocation of group therapy minutes as discussed above and in the FY 2012 proposed rule (76 FR 26387). As is currently the procedure, the SNF will report the total unallocated group therapy minutes on the MDS 3.0. In terms of RUG-IV classification, this total time will be allocated (that is, divided) among the four group therapy participants to determine the appropriate number of RTM and, therefore, the appropriate RUG-IV therapy group and payment level, for each participant. In addition, as discussed above, if one or more of the four group therapy participants are unexpectedly absent from a session or cannot finish participating in the entire group session, rather than discontinuing payment or requiring the session to be rescheduled, we will continue to deem the therapy session as meeting the definition of group therapy as long as the therapy program originally had been planned for four patients. In this situation, we will continue to assume that there are four patients, and therefore will divide the therapy minutes by four in allocating group therapy minutes among the group therapy participants. (76 Fed. Reg. 48517)

Current Policy: Under a Part A SNF stay, groups for therapy can consist of 2 to 4 people interacting with each other as they perform the same or similar activities. All minutes that the patient is in the group activity are recorded on the MDS (e.g., if a group lasts 60 minutes, the MDS would reflect 60 minutes of group therapy for each person in the group). Also in current policy, there is a limit on the amount of group therapy that can be counted as minutes to determine RUG classification. Group therapy cannot comprise more than 25% of the total weekly therapy minutes for each patient.

CMS stated that following last year's policy changes, there was a major decrease in the amount of concurrent therapy performed in SNFs and a significant increase in the amount of group therapy services. CMS believes that allocating concurrent therapy minutes and not group therapy minutes may have created an inappropriate payment incentive to perform group therapy in place of individual or concurrent therapy.

New Policy Effective October 1, 2011: For any assessments with an ARD on or after October 1, 2011, group therapy minutes will be allocated regardless of whether the look back period extends prior to October 1, 2011. CMS will allocate minutes of group therapy based on a group size of four patients. CMS believes that a four-person group is the most effective group size and stated, "We believe that groups of fewer than four participants do not maximize the group therapy benefit for the participants." In situations where the definition of group therapy is not met, those minutes cannot be coded on the MDS as group therapy. The minutes of therapy time will be counted based on the therapist's time rather than the time the patient spends receiving therapy. CMS believes that when a therapist treats four patients in a group for an hour, it does not cost the SNF four times the amount (or four hours of a therapist's salary) to provide those services. Therefore, CMS believes that allocating group therapy minutes among the four group therapy participants would best capture the resource utilization and cost. CMS will allocate "**reimbursable therapy minutes (RTM)**" as a method to classify patients into RUG-IV categories. RTMs will be based on the therapist's time, as opposed to the patient's time, in the group. CMS will allocate minutes based on a four-person group, regardless of number of people that actually participated. For example, if a group is scheduled for 60 minutes, each person will receive 15 minutes of therapy time on the MDS. This will be true even if one or more people are unable to attend. The 25% of total therapy per week per patient policy remains unchanged, as CMS continues to believe that group therapy should serve only as an adjunct to individual therapy. CMS expects group therapy to be a structured, planned program with four participants for whom group therapy has been determined appropriate. CMS believes that group therapy sessions should not fluctuate in size or membership.

CMS acknowledged that it was not able to find research data to support any prescribed number of participants in a therapy group, but maintained its position that four participants is the optimal number. In response to comments, CMS stated that it does not believe that the allocation of group therapy minutes should be considered a deterrent to having group therapy sessions or should negatively affect beneficiaries. CMS emphasized that it expects therapists to continue to provide the mode of therapy that is most clinically appropriate for each patient. CMS will continue to monitor group therapy utilization and will continue to consult with clinical experts, professional therapy associations, and other stakeholders on this issue.

Therapy Documentation

CMS finalized its clarification of documentation requirements for group therapy documentation. CMS requires that therapy documentation justify the use of individual,

concurrent, or group therapy and include ongoing support based on the patient's needs and goals.

Under current Medicare requirements, a patient's plan of care must prescribe the type, amount, frequency, and duration of physical therapy, occupational therapy, or speech-language pathology services. CMS expects each patient's plan of care to include ongoing supporting documentation and indicate the diagnosis and anticipated goals. CMS stated in the proposed rule that this clinical documentation has always been necessary to identify when significant changes in a patient's medical condition occur. It is also required so that contractors can verify medical necessity when they review SNF claims.

CMS adopted clarifications to its expectations for clinical documentation needed to support each patient's plan of care, including group therapy interventions. Clinical documentation, including the patient's medical record, therapy notes, and/or other related documentation, must demonstrate how the prescribed skilled therapy services contribute to the patient's anticipated progression toward the prescribed goals. The plan of care must include an explicit justification for the use of group, rather than individual or concurrent, therapy. This description should include, but not be limited to, the specific benefits to that particular patient including the documented type and amount of group therapy; in other words, how the prescribed type and amount of group therapy will meet the patient's needs and assist the patient in reaching the documented goals.

Documentation also needs to include ongoing support based on the patient's needs and goals. If the use of therapy services deviates significantly from the patient's original plan of care, the therapist must update the plan of care as well as the patient's goals. To demonstrate that changes to the mode and/or intensity of therapy are medically necessary, the provider should clearly describe in the plan of care the reasons for deviating from the original care plan. CMS expects that the data reported in both scheduled and unscheduled assessments will provide an accurate representation of the skilled therapy and nursing needs of the patient. If there is a change in clinical and therapy status that affects the accuracy of the resident's most recent assessment, then CMS expects the changes to be documented and used to determine if they would result in a reclassification of the resident's case-mix group.

MDS 3.0 Assessment Schedule and Other Medicare-Required Assessments

CMS adopted the following proposals:

- Modified the current Medicare-required assessment schedule to incorporate new assessment windows and maintain grace days, in order to avoid duplicative assessments and capture changes in the patient's status
- Clarified that for purposes of setting the Assessment Reference Date (ARD), an End of Therapy (EOT) OMRA must be completed when the patient does not

receive therapy for 3 consecutive days and create End-of-Therapy-Resumption (EOT-R) OMRA

- Eliminated the distinction between 5-day and 7-day facilities for purposes of setting the ARD for the EOT OMRA
- Required weekly assessment of minutes to determine whether patient's status has changed and create Change of Therapy (COT) OMRA as a new PPS assessment to assign the patient to the appropriate RUG-IV classification and payment if the patient's status has changed

For SNF PPS, scheduled assessments (5-Day, 14-Day, 30-Day, 60-Day, and 90-Day assessments) must be completed within designated time frames. The therapy portion of the assessment is based on a 7-day look-back at therapy services from an ARD. The ARD is chosen from an assessment window that includes defined days and grace days for each assessment. The amount of skilled, ordered therapy provided in the look-back period determines the RUG category for each corresponding payment period. The MDS coordinator depends on the ongoing documentation provided by the occupational therapist and/or occupational therapy assistant in the record. It is the occupational therapist's responsibility to ensure that reevaluations and patient progress are properly documented in the record to assist the MDS coordinator in correctly completing the OMRAs.

In the final rule, CMS agreed that licensed therapists are to use their clinical judgment to treat patients in the most appropriate manner, and to maintain professional standards while providing all necessary services.

CMS believes that the combination of the grace period allowance and observation period could cause MDS assessments to overlap or be too close together to be informative. The assessments are intended to capture changes in the patient's status. CMS believes that its modifications to the current assessment schedule will avoid duplicating information on assessments and better capture changes in patient status (and related changes in RUG category and payment). CMS believes it will improve patient and provider satisfaction, as well as care quality, because therapists will not have to repeat interview questions within a short amount of time, as sometimes happens now. CMS kept the grace periods in place and encourages the use of grace days if their use will allow a facility more clinical flexibility or will more accurately capture therapy and other treatments. CMS may explore the option of incorporating the grace days into the regular ARD window in the future. CMS does not intend to penalize any facility that chooses to use the grace days for assessment scheduling or to audit facilities based solely on their regular use of grace days.

The current and new MDS 3.0 Assessment Schedules appeared in the proposed rule:

TABLE 10A—CURRENT MDS 3.0 ASSESSMENT SCHEDULE

Medicare MDS assessment type	Reason for assessment (A0310B code)	Assessment reference date window	Assessment reference date grace days	Applicable medicare payment days
5 day	01	Days 1–5	6–8	1 through 14.
14 day	02	Days 11–14	15–19	15 through 30.
30 day	03	Days 21–29	30–34	31 through 60.
60 day	04	Days 50–59	60–64	61 through 90.
90 day	05	Days 80–89	90–94	91 through 100.

TABLE 10B—PROPOSED MDS 3.0 ASSESSMENT SCHEDULE

Medicare MDS assessment type	Reason for assessment (A0310B code)	Assessment reference date window	Assessment reference date grace days	Applicable medicare payment days
5 day *	01	Days 1–5	6–8	1 through 14.
14 day	02	Days 13–14	15–18	15 through 30.
30 day	03	Days 27–29	30–33	31 through 60.
60 day	04	Days 57–59	60–63	61 through 90.
90 day	05	Days 87–89	90–93	91 through 100.

* Changes would also apply to Readmission/Return Assessment (A0310B code = 06).

CMS adopted the proposed schedule as it appears above, and it is effective October 1, 2011. Any ARDs set after October 1, 2011, must be in line with the updated assessment schedule. NOTE: When October 1, 2011, is Day 19, 34, 64, or 94 of the stay, assessments should be completed by September 30 or the assessments will be considered late and payment penalties will apply.

In addition, CMS clarified that for the purposes of setting the ARD, an EOT OMRA must be completed when the patient does not receive therapy for 3 consecutive days. This is regardless of the reason for discontinuing therapy. CMS eliminated the distinction between 5- and 7-day facilities. Effective October 1, 2011, facilities will be considered 7-day facilities for the purposes of setting the ARD for an EOT OMRA. As October 1, 2011 is a Saturday, this day should be counted as a day of missed therapy if a patient does not receive any therapy services on that day. In response to comments expressing concerns about the elimination of the distinction between 5- and 7-day facilities, CMS stated its primary concern is that SNF residents receive daily skilled rehabilitation. CMS cited § 409.31(b)(1) which requires skilled services on a daily basis, as well as § 409.34(a)(2) which requires skilled services at least 5 days a week to support its policy that a facility must ensure that therapy is provided for at least 5 days a week. CMS believes that this policy appropriately reflects that the frail and vulnerable populations within SNFs require consistent therapy without significant breaks in service. CMS stated that it is the facility's responsibility to ensure that patients receive ongoing, rather than sporadic, care to promote each patient reaching his or her full potential. If an EOT OMRA is completed and therapy resumes, the SNF may perform a therapy evaluation or complete the optional Start-of-Therapy (SOT) OMRA to re-classify the patient into a therapy RUG-IV group.

End-of-Therapy Resumption (EOT-R) OMRA

Providers had suggested to CMS that they should not be required to complete an EOT and SOT OMRA for patients who resume therapy at the same mode and intensity they were receiving before discontinuation of therapy. In response, CMS created an EOT-R OMRA, effective for all EOT OMRA assessments with an ARD on or after October 1, 2011. When a patient does not receive therapy for no more than 5 consecutive calendar days and resumes therapy at the same RUG-IV classification level (mode & intensity) as before, then the provider may complete an EOT-R. CMS added two new items (O0450A and O0450B) to the EOT OMRA item set so that it can be used as an EOT-R OMRA. The MDS coordinator completes these forms based on therapy documentation and input from the therapist.

CMS included the following examples regarding the use of an EOT-R OMRA:

Mr. A. received therapy every day Monday through Friday. He missed therapy on Saturday and Sunday because the SNF he was in did not provide therapy during the weekend. On Monday, Mr. A.'s family came to visit and he refused therapy. At this point, Mr. A. missed 3 days of therapy and an EOT OMRA would be required. He also missed therapy on Tuesday, due to a scheduled doctor's appointment. The interdisciplinary team made the determination that Mr. A.'s missed therapy did not result in a change in clinical condition that would make him tolerate less therapy and change his RUG-IV classification. Therefore, the facility completed an EOT OMRA on Monday indicating that therapy had not occurred for at least three days. Then, on Wednesday, the EOT is modified into an EOT-R by reporting the actual date of resumption, which was Wednesday. In this case, a new therapy evaluation was not required and Mr. A resumed therapy on Wednesday at the same RUG-IV classification level.

In cases where the patient resumes therapy more than 5 consecutive calendar days after discontinuation of therapy services or where the patient resumes therapy at a different RUG classification level (even if it is no more than 5 consecutive calendar days after the date the last therapy service was furnished), an EOT-R OMRA cannot be used. In this case, the facility could either complete an optional SOT-OMRA and new therapy evaluation if therapy resumes, or wait until the completion of the next scheduled PPS assessment to classify the resident into a RUG-IV group. If the facility chooses not to complete an SOT OMRA and if the next scheduled PPS assessment is used to classify the patient into a therapy RUG group, a new therapy evaluation would also be required.

For example: Mr. B. received therapy every day Wednesday through Monday. On Tuesday, he felt ill and missed therapy that day and Wednesday. He then went to dialysis on Thursday and missed therapy that day as well. He missed a total of 3 days of therapy. Due to his illness and dialysis, he could not immediately resume therapy at the same level he was receiving prior to the three missed days. However, on Friday he felt well enough to start therapy again. The facility completed an EOT OMRA on Thursday to classify Mr. B. into a non-rehabilitation RUG group and to get paid the non-rehabilitation RUG rate for

Tuesday, Wednesday, and Thursday. As Mr. B. could not resume therapy at the same RUG–IV classification level, a new therapy evaluation was completed by each discipline (physical therapy, occupational therapy, and/or speech therapy) treating Mr. B. and then an SOT OMRA was completed, and he was placed back into a rehabilitation RUG group. The facility was paid at the rehabilitation RUG rate from the day therapy restarted until the next PPS assessment was completed.

Advance Beneficiary Notice (ABN) and Notice of Medicare Non-coverage (NOMNC)

CMS discussed Advance Beneficiary Notices (ABNs) in the proposed rule. Providers had asked whether they need to issue an ABN every Friday to anticipate the possibility that a resident might be unable or unwilling to do therapy on Monday (which would require an EOT OMRA). In the proposed rule, CMS advised providers that the decision to issue an ABN is individualized and should not be applied across the board to all patients. CMS said it is not appropriate to issue ABN until therapy is discontinued.

CMS received comments requesting additional guidance about the use of ABNs and the NOMNC. CMS responded that the policies for issuance of the SNF ABN and an NOMNC have not changed. CMS referred providers to the current manual instructions in the Medicare Claims Processing Manual, IOM 100-04, Chapter 30, Section 70 (see <https://www.cms.gov/manuals/downloads/clm104c30.pdf>).

CMS indicated that if SNF covered services end solely because a beneficiary fails to meet the consecutive days of therapy requirement either because therapy is not offered on those days or the beneficiary refuses or declines therapy, or any combination of those reasons, a NOMNC would not be issued. An NOMNC is not issued when a beneficiary initiates the end of care, or when care ends for provider business reasons, such as when a SNF does not offer therapy on certain days. CMS will publish guidance on NOMNC delivery in the Medicare Claims Processing Manual in the near future and will also include further clarification on NOMNC delivery in other vehicles such as CMS Open Door Forums, as deemed necessary.

Change of Therapy (COT) OMRA

CMS found that sometimes therapy services recorded in a PPS assessment do not provide an accurate account of the therapy provided to a patient outside the observation window used for the most recent assessment because changes may not rise to the level of a significant change in clinical status and therefore generate an unscheduled assessment. As a result, CMS created a COT OMRA. Whenever the intensity of therapy changes to a degree that no longer reflects the RUG-IV classification and payment assigned to the patient based on the most recent assessment, the SNF must complete a COT OMRA. This applies whether the change in RTM is a scheduled change or an unscheduled or unplanned change, and whether the different RUG category is higher or lower than the RUG category in which the resident is currently placed.

The COT OMRA is completed using the same item set as the current EOT OMRA. The ARD of the COT OMRA would be set for Day 7 of a COT observation period, which is a successive 7-day window beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment (or beginning the day therapy resumes in cases where an EOT–R OMRA is completed), and ending every 7 calendar days thereafter. The provider must assess the patient’s RTMs every 7 days to determine whether they need to do a COT OMRA. The COT OMRA requirements, including the COT observation period requirement, also apply in cases where a resident is receiving therapy but is classified into a nursing RUG because of index maximization. The COT OMRA requirements are effective for all assessments with an ARD on or after October 1, 2011.

CMS believes the COT OMRA will allow them to track changes in the patient’s condition and in the provision of therapy services more accurately, allowing reimbursement to reflect resource use more accurately, thereby improving the accuracy of reimbursement. Being able to track these changes will also enhance a SNF’s ability to provide quality care to residents.

CMS received comments of concern about the changes to assessment schedules. CMS is confident that these changes allow sufficient time to perform all required assessments, allow for flexibility in scheduling the assessments, and provide a more accurate method for determining payment across the entire 30-day period. CMS will update the RAI Manual to incorporate the changes and instructions for assessments and will provide training opportunities prior to the October 1, 2011 implementation. CMS stated that it will monitor the effects of the changes and make any necessary modifications through future rulemaking.

Additional Resources

[CMS FY 2012 SNF PPS Transition Policy Memo](#)

CMS Press Release: [CMS Announces More Accurate FY 2012 Payments for Medicare Skilled Nursing Facilities](#)

[CMS Final SNF PPS Rule](#)

[AOTA Comments on Proposed SNF Rule](#)

[AOTA Analysis of Proposed SNF PPS Rule](#)

[AOTA Notice and Overview of Proposed Rule](#)

[SNF PPS Proposed Rule](#) in the *Federal Register*

[OIG Report: Changes in SNF Billing in FY 2011](#)

[CMS Chart: Therapy Minutes by Mode for Different Ownership Status Types](#)

[RUG-III and RUG-IV Distribution of Service Days Based on FY 2011 data](#)

[Determining RUG-III Group Distribution Based on MDS 3.0 Data](#)

[CMS Student Supervision Guidelines](#)

[OT/OTA Student Supervision & Medicare Requirements](#)

[Practice Advisory: Services Provided by Students in Fieldwork Level II Settings](#)

[Comparison of Expected versus Actual RUG-IV Utilization](#)

[MDS 3.0 RAI Manual](#). For therapy coding instructions and guidance on the use of aides and students, as well as modes of therapy, see the MDS 3.0 RAI Manual document at the bottom of the Web page and go to Chapter 3, Section O, in the zip file.

[CMS SNF PPS Updates & Recent Data](#)

[CMS SNF PPS Web Site](#)

[Everything You Need To Know if You Work in a SNF](#)

For more information, see www.aota.org or contact us at rrpd@aota.org.