This [2012 SNF PPS Final Rule](#) updates the payment rates used under the prospective payment system (PPS) for Skilled Nursing Facilities (SNFs) for fiscal year 2012. The rule finalizes most provisions in the proposed rule, including the recalibration of the case-mix indexes and changes relating to MDS 3.0 reporting. All changes are effective Oct. 1, 2011. To determine how this final rule will affect your facility’s Part A Medicare SNF payment, use [LeadingAge’s SNF Rate Calculation Tool](#).

### Payment Update

- **Market Basket Update**: The 2012 market basket increase factor is +2.7%. This update is reduced by the productivity adjustment, as required by law, by 1%, resulting in an adjusted market basket update of +1.7% ($600 million).

- **Recalibration and Overall Payment Update**: Using more data representing 8 months of FY 2011, CMS has determined that the utilization patterns they had first identified in the first quarter of 2011 have continued for another 2 quarters. As a result, CMS decided to implement the proposed recalibration adjustment of -12.6% ($4.47 billion). This cut, coupled with the 1.7% market basket update results in a net update of **-11.1%** ($3.87 billion) in payment for FY 2012. As proposed, CMS will apply the new parity adjustment to only the nursing CMIs within the RUG-IV therapy groups. No parity adjustment will be applied to the non-rehab groups.

- **AIDS Add-On**: The 128% in the per diem adjusted payment rate for residents with AIDS remains in effect.

### MDS Reporting

- **Therapy Student Supervision**: CMS finalized their proposal that line-of-sight supervision should no longer be required in the SNF setting. Each SNF should determine the appropriate way of supervision of therapy students according to State and local laws and practice standards. This policy does not change the way therapy minutes are currently coded for in the MDS 3.0, so the time the student spends with the resident will continue to be billed as if it were the supervising therapist alone providing the therapy.

- **Group Therapy**:
  - **Definition**: CMS has clarified the definition of group therapy to the practice of one professional therapist treating 4 patients at the same time while the patients are
performing the **same or similar therapy activities** and are supervised by a therapist (or assistant) who is not supervising any other individuals.

- **Number of Patients**: CMS is finalizing its proposal to limit group therapy to exactly 4 patients who are performing the same or similar therapy activities. CMS’s explanation to limiting the group to 4 patients is that larger groups with more than 4 patients make it difficult for patients to learn from one another and therapists to supervise. CMS also claims that groups with fewer than 4 participants don’t maximize the benefits associated with the group setting. The supervising therapist may not supervise any individuals other than the 4 who are in the group session.

- **Allocation of Minutes**: CMS will allocate all group therapy minutes to appropriately reflect resource utilization and costs (i.e. therapist’s time, not resident’s time). The SNF will report the total unallocated group therapy minutes on the MDS 3.0 (as currently done with concurrent therapy), and the software will divide those total minutes by 4 to determine the RUG-IV therapy group and payment level for each resident.

  *In cases where the definition of group therapy is NOT met (required to have 4 participants), those minutes may NOT be coded on the MDS as group therapy. However, if the therapy session was originally planned for 4 patients, but 1 or more of the 4 participant is unexpectedly absent for whatever reason, then CMS will deem that session as “group”. As such, CMS will assume 4 participants and will, therefore, divide those therapy minutes by 4 among the remaining group participants.*

- **25% Cap**: This 25% cap will remain in effect for 2012. The cap is a way to restrict group therapy as a supplemental treatment to individual therapy. The cap will be applied to the resident’s reimbursable group therapy minutes.

- **Group Therapy Documentation**: CMS clarified that SNFs should continue to justify group therapy as part of the patient’s plan of care with appropriate documentation including, but not limited to, the benefits the patient will get from a group therapy setting. CMS emphasized that this provision is not a new documentation requirement for group therapy, but something that SNFs are already required to do. Other than the original therapy plan of care required for therapy in a SNF, CMS is NOT requiring an additional and separate plan of care for group therapy.

- **Assessment Schedule**: CMS has finalized changes to the patient assessment schedule with the proposed new assessment windows and grace periods (see chart 1 below). CMS states that these changes were made to capture more appropriately changes in patient’s status for treatment and payment purposes, to reduce redundant information that were being coded in two subsequent assessments, and to reduce the need for multiple interviews within a short period of time.
Chart 1: New Assessment Schedule

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>Reason for Assessment (A0310B Code)</th>
<th>Assessment Reference Date (ARD) Window</th>
<th>Assessment Reference Date (ARD) Grace Days</th>
<th>Applicable Medicare Payment Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 day</td>
<td>1</td>
<td>Days 1 – 5</td>
<td>6 - 8</td>
<td>1 through 14</td>
</tr>
<tr>
<td>14 day</td>
<td>2</td>
<td>Days 13 - 14</td>
<td>15 – 18</td>
<td>15 through 30</td>
</tr>
<tr>
<td>30 day</td>
<td>3</td>
<td>Days 27 – 29</td>
<td>30 - 33</td>
<td>31 through 60</td>
</tr>
<tr>
<td>60 day</td>
<td>4</td>
<td>Days 57 - 59</td>
<td>60 – 63</td>
<td>61 through 90</td>
</tr>
<tr>
<td>90 day</td>
<td>5</td>
<td>Days 87 – 89</td>
<td>90 – 93</td>
<td>91 through 100</td>
</tr>
</tbody>
</table>

- **EOT OMRA:** CMS once again clarified on this final rule that the Assessment Reference Date (ARD) for an End-of-therapy (EOT) OMRA must be set for 1 to 3 days after the discontinuation of all therapies. CMS also clarified that SNFs must complete an EOT OMRA for a patient if that patient goes 3 consecutive days without therapy, regardless of the reason for the discontinuation (temporary, unplanned and planned).

With these clarifications, CMS finalized its proposal to eliminate the distinction between a 5-day facility (facilities that provide therapy services 5 days a week, usually not on the weekends) vs. a 7-day facility (facilities that provide therapy services 7 days a week). Effective Oct. 1, 2011, all facilities will be considered “7-day facilities”, so that the 3 consecutive days counts even for weekends whether a SNF regularly provides therapy on weekends or not. CMS suggests that SNFs that cannot meet their daily skilled rehabilitation requirements revisit their hiring and staffing practices as well as their admissions policies to make sure that they are able to provide the daily skilled care as needed by their residents.

- **EOT -R OMRA:** Effective Oct. 1 2011, when a EOT OMRA has been completed and therapy subsequently resumes, SNFs may complete an End-of-therapy- Resumption (EOT-R) OMRA instead of an Start-of-therapy (SOT) OMRA and new evaluation. An EOT-R is voluntary and may only be used in cases where therapy is expected to resume (and does resume) within 5 consecutive days after the last day of therapy at the same RUG-IV level as before the EOT OMRA.

CMS clarified that the EOT-R is not a new assessment type – it is an EOT OMRA with two additional items (O0450A and O0450B) that is used to indicate if therapy is expected and eventually resumes at the date of resumption of therapy. Therefore, if a facility completes an EOT OMRA because the resident missed 3 consecutive days of therapy, and say, on a later date (within 5 days of the most recent EOT OMRA), the resident resumes therapy at the same RUG...
level, the last EOT OMRA is then modified into an EOT-R OMRA by reporting the actual date of resumption.

If therapy does not resume 5 consecutive days after the last EOT OMRA, facilities do not have the option of completing the EOT-R OMRA, even if therapy resumed at the same RUG level as before. In this case, SNFs would either have to complete an optional SOT OMRA and a new therapy evaluation if therapy resumes or wait until the next scheduled assessment.

- **COT OMRA:** SNFs are now required to complete a new type of assessment, the Change of Therapy (COT) OMRA, whenever the intensity of therapy (total reimbursable therapy minutes delivered) for a resident changes (for any reason) to such an extent (higher or lower) that it no longer reflects the RUG classification that resident was originally classified in based on their last PPS assessment. The ARD will have to be set for day 7 of a COT observation period. The observation period is a 7-day window beginning on the day following the ARD for the most recent scheduled or unscheduled PPS assessment, or beginning the day therapy resumes for EOT-R, and ending every 7 days.

CMS clarified that ADL scores are not considered when deciding whether there is a need to complete a COT OMRA, although the ADL score will be used to determine the appropriate RUG group in which that resident will be classified. CMS also clarified that a COT would apply in cases where a resident is receiving therapy but is classified into a nursing RUG due to index maximization (something that would not happen often).

In cases where the COT OMRA is combined with a regularly scheduled assessment, the SNF needs to complete the scheduled assessment instead of the COT OMRA because the COT OMRA only includes a subset of the required MDS data. The full MDS assessment will then be used for payment for both the COT observation period and the applicable Medicare payment days.

CMS Ex: if day 7 of the COT observation period falls in the ARD window of the 30-day PPS assessment, the SNF needs to set the ARD for the 30-day assessment on day 7 of the COT OMRA observation period and code the reasons for assessment as both the 30-day and the COT (items AO310(B) and AO310(C)).

The ARD for the COT OMRA is day 7 following the last assessment or unscheduled PPS assessment or day 7 following the end of the last COT observation period (if a COT OMRA was not necessary because therapy did not change enough to bump resident into a higher or lower RUG).

The new RUG-IV group resulting from a COT OMRA would be billed starting the first day of the COT observation period and would remain at that level until a new assessment is completed and changes the patient’s RUG classification.
If a COT OMRA is required but completed late, the SNF must still submit that late COT OMRA, and will be paid the default rate for all days NOT in compliance with the ARD requirement. In this case, the ARD of the late COT OMRA restarts the 7-day observation period for the next COT OMRA.

CMS estimates that the COT OMRA will take approximately 62 minutes to complete: 50 minutes to collect the information for coding the COT OMRA; 10 minutes to code the responses; and 2 minutes to transmit the results. The estimated costs per OCT OMRA is $33.8. CMS predicts that the average number of times that a COT OMRA would be completed due to a decrease in therapy would be close to once per stay, and the total number of estimated COT OMRAs per SNF for decreases in therapy would be about 57. For increases in therapy, CMS estimates that COTs would be needed 5 times per facility per year.

- **SNF ABN:** CMS once again clarified that the SNF Advanced Beneficiary Notice (ABN) is issued to beneficiaries before delivering services for which Medicare may not pay because the services become not medically reasonable and necessary (i.e. custodial care). The **SNF ABN policy** has not changed with this final rule.

CMS clarified that there is no “48-hr notice” requirement. The requirement is that a SNF ABN is given in a timely manner (and before the non-covered care is provided) such that it provides the beneficiary sufficient time to make a decision to receive care that may not be covered under Medicare, and/or make other arrangement for care.

SNFs should give the beneficiary an ABN as soon as it becomes evident that the beneficiary will enter a non-covered stay (non-Part A). CMS also clarified that just because a resident misses 3 consecutive days of skilled therapy, that doesn’t necessarily trigger the need for an ABN. If the resident is still receiving non-therapy skilled care, Medicare Part A may still cover that resident, so the SNF will not need to issue an ABN.

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**MDS 3.0 Training of New MDS 3.0 Policies**

- CMS is developing training programs to assist providers to adapt to new policy changes that will be effective Oct 1, 2011. The first of those training programs will be in Aug. 23. More detailed information, including registration, visit the following CMS website: [http://www.eventsvc.com/palmettogba/082311](http://www.eventsvc.com/palmettogba/082311)

- LeadingAge is also working on future educational opportunities that addresses these proposed MDS 3.0 reporting changes and will notify its membership once more information becomes available.
• CMS will publish a separate final rule early in CY 2012 specifically addressing provisions related to required disclosure of ownership and additional disclosable parties’ information.

Read the [2012 SNF PPS Final Rule](#)

Use [LeadingAge’s SNF Rate Calculation Tool©](#) to determine 2012 rates.