CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 924	**Date: November 15, 2019**
	Change Request 11520

SUBJECT: Updates to the Medical Review Instructions Related to Skilled Nursing Facilities (SNF)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to ensure the medical review instructions in Publication (Pub.) 100-08 align with the regulatory updates issued in final rule CMS-1696-F that created the Patient Driven Payment Model (PDPM), which replaces the prior Resource Utilization Group (RUG) classification system, effective October 1, 2019.

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 17, 2109

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row*.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/6.1/Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills
R	6/6.1/6.1.1/Skilled Nursing Facility Qualifying Inpatient Stay
R	6/6.1/6.1.2/Types of SNF PPS Review
R	6/6.1/6.1.3/Claim Review Requirements
R	6/6.1/6.1.4/Medical Review Process

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 924	Date: November 15, 2019	Change Request: 11520

SUBJECT: Updates to the Medical Review Instructions Related to Skilled Nursing Facilities (SNF)

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 17, 2019

I. GENERAL INFORMATION

A. Background: The CMS issued a final rule [CMS-1696-F] that created the PDPM, which replaces the prior RUG classification system, effective October 1, 2019. This CR ensures the medical review instructions in the Pub. 100-08 align with the regulatory updates.

B. Policy: There are no regulations, legislation, or statutes related to this CR.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11520.1	Contractors shall conduct medical reviews of SNF Prospective Payment System (PPS) services in accordance with Chapter 6 of Pub. 100-08, which has been updated to reflect the regulatory updates issued in CMS-1696-F. NOTE—Contractors shall note that the business requirements contained in this CR are provided to emphasize the PDPM changes/other updates, but per this business requirement, the manualized instruction shall be applied in its entirety.	X								CERT, RAC, SMRC, UPICs
11520.2	Contractors shall determine the appropriateness of SNF PPS payments based upon the patient's condition and the application of the CMS prescribed case-mix model and payment classification system.	X								CERT, RAC, SMRC,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
										UPICs
11520.3	Contractors shall base their medical review decisions on documentation provided to support the coding and medical necessity of services recorded on the Minimum Data Set (MDS) for the claim period billed.	X								CERT, RAC, SMRC, UPICs
11520.4	Contractors shall focus on the unique, individualized needs, characteristics and goals of each patient, in conjunction with our payment policies, to determine the appropriateness of the case-mix classifier billed.	X								CERT, RAC, SMRC, UPICs
11520.5	Contractors shall review SNF PPS services covered by the consolidated billing policy in accordance with their medical review strategies. Note: SNF services excluded from consolidated billing are identified in §4432(a) of the Balanced Budget Act (BBA) and regular updates which can be accessed by contractors at: http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.	X								CERT, RAC, SMRC, UPICs
11520.6	Contractors shall presume that beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay meet the level of care requirements of 42 Code of Federal Regulations (CFR) 409.31 for the period of time up to and including the assessment reference date for the initial Medicare assessment (commonly referred to as the "5-day" assessment) prescribed in 42 CFR 413.343(b), when correctly assigned to one of the more intensive case-mix classifiers.	X								CERT, RAC, SMRC, UPICs
11520.6.1	Contractors shall refer to section 6.1.4 of chapter 6 in Pub. 100-08, and section 30.1	X								RAC,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	in Pub. 100-02 (including item 3 of that section for a discussion of a rehospitalization that exceeds the 3-day interruption window specified under the SNF PPS's interrupted stay policy) for a further explanation of the administrative presumption of coverage.									SMRC, UPICs
11520.7	Contractors shall refer to chapter 3 of Pub. 100-08 for instructions related to targeted probe and education medical review.	X								CERT, RAC, SMRC, UPICs
11520.8	Contractors reviewing demand bills shall-- (i) review the medical record to determine that both technical and clinical criteria are met; and (ii) if so, and some or all services provided were reasonable and necessary, use the MDS QC System Software (as necessary) to determine the appropriate case-mix classifier.	X								CERT, RAC, SMRC, UPICs
11520.9	Contractors shall assess HIPPS codes to ensure-- (i) The first character represents the patient's physical therapy (PT) component and occupational therapy (OT) component classification; (ii) The second character represents the patient's speech-language pathology (SLP) component classification; (iii) The third character represents the patient's nursing component classification; (iv) The fourth character represents the patient's non-therapy ancillary (NTA) component classification; and (v) The fifth character represents the assessment indicator (AI) code. Note: See Pub. 100-04, chapter 6, section 30.1 for valid codes and assessment indicators.	X								CERT, RAC, SMRC, UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11520.10	Contractors shall use the QIES (Quality Improvement & Evaluation System) Business Intelligence Center (QBIC) Fiscal Intermediary (FI) Extract Reports to obtain the MDS data from the National Reporting repository. Note: Information (QBIC documentation & training) can be found at https://qtso.cms.gov. (Search for 'QBIC' when accessing the webpage.)	X								CERT, RAC, SMRC, UPICs
11520.11	Contractors shall ensure the services must not be statutorily excluded. (Note this is not a new requirement—there was a change in placement of this instruction).	X								CERT, RAC, SMRC, UPICs
11520.12	Contractors shall require that the provider submit the claim with the case-mix classifiers obtained from the "Grouper" software, as instructed in section 30.1 of chapter 6 in Pub. 100-04, and shall deny claims for which the MDS has not been transmitted to the repository.	X								CERT, RAC, SMRC, UPICs
11520.12.1	Contractors shall note that an exception to the above instruction occurs in the case where the beneficiary is discharged or dies on or before day 8 of the SNF admission or readmission, as described in Chapter 2 of the MDS 3.0 RAI manual.	X								CERT, RAC, SMRC, UPICs
11520.13	Contractors shall ensure that SNFs have complied with the assessment schedule - in accordance with 42 CFR §413.343, and in those instances when the assessment is not completed timely, pay at the default rate for any days of care prior to the assessment reference date of the required assessment.	X								CERT, RAC, SMRC, UPICs
11520.13.1	Contractors shall note that the Interim Payment Assessment (IPA) is an optional	X								CERT,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	assessment that providers may complete to report a change in the patient's classification. If an IPA has been completed, contractors shall examine the medical documentation as described in this chapter.									RAC, SMRC, UPICs
11520.14	Contractors shall, in making a reasonable and necessary determination, determine whether the services indicated on the MDS were rendered and were reasonable and necessary for the beneficiary's condition as reflected by medical record documentation.	X								CERT, RAC, SMRC, UPICs
11520.14.1	Contractors shall, if the reviewer determines that none of the services provided were reasonable and necessary or that none of the services billed were supported by the medical record as having been provided, deny the claim in full.	X								CERT, RAC, SMRC, UPICs
11520.15	Contractors shall note that the previously mentioned policy that allows the 5-day assessment to trigger a presumption of coverage applies only when the SNF admission directly follows discharge from a prior qualifying hospital stay. Note: See section 30.1 in chapter 8 of Pub. 100-02, for further explanation of the administrative presumption of coverage.	X								CERT, RAC, SMRC, UPICs
11520.16	Contractors shall, if an administrative presumption of coverage exists, review the claim and supporting medical information specifically to confirm the correctness of the case-mix classifier assignment that triggered the presumption.	X								CERT, RAC, SMRC, UPICs
11520.17	Contractors shall, to determine if the beneficiary was correctly assigned to a case-mix classifier, verify that the billed case-mix classifier is supported by the	X								CERT, RAC,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	associated provider documentation--considering all available information in determining coverage, such as the MDS, medical records (including physician, nursing, and therapy documentation), and the beneficiary's billing history.									SMRC, UPICs
11520.18	Contractor shall ensure all pertinent information is included in the claim case file for any future reviews or related appeals, such as the relied upon billing history.	X								CERT, RAC, SMRC, UPICs
11520.19	Contractors shall, for all other beneficiaries who were *not* subject to a presumption (and designated as meeting the required level of care on the 5-day assessment), perform individual level of care determination using existing administrative criteria and procedures, and verify that the documentation supports that the beneficiary meets the level of care requirements.	X								CERT, RAC, SMRC, UPICs
11520.20	Contractors shall, for days after the assessment reference date of the 5-day assessment, determine the continued need for, and receipt of, a skilled level of care based on the beneficiary's clinical status and skilled care needs for the dates of service under review.	X								CERT, RAC, SMRC, UPICs
11520.21	Contractors shall pay claims according to the case-mix classifier value calculated using the MDS QC tool, regardless of whether it is higher or lower than the case-mix classifier billed by the provider.	X								CERT, RAC, SMRC, UPICs
11520.22	Contractors shall verify that the case-mix classifier submitted on the claim matches the case-mix classifier on the MDS imported from the national repository into	X								CERT, RAC, SM

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the MDS QC tool, and: • If the facility case-mix classifier obtained through the MDS QC tool matches the case-mix classifier submitted on the claim, the contractor shall pay the claim as billed for all covered days associated with that MDS, even if the level of therapy changed during the payment period. • If the facility case-mix classifier obtained through the MDS QC tool does not match the case-mix classifier submitted on the claim, the contractor shall pay the claim at the appropriate level based on the case-mix classifier level on the MDS submitted to the repository (and subsequently obtained through the MDS QC tool) for all covered days associated with that MDS, even if the services provided changed during the payment period.									RC, UPICs
11520.23	If *some* skilled services were appropriate while others were not reasonable and necessary or were not supported by the medical record as having been provided as billed, and the reviewer determines (based on data entered from the medical record into the MDS QC System Software) that: • The discrepancies are such that they do not result in a change in the case-mix classification level as calculated by the MDS QC tool, during the relevant assessment period for the timeframe being billed, the contractor shall accept the claim as billed for all covered days associated with that MDS, even if the level of skilled care changed	X								CERT, RAC, SMRC, UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	during the payment period. • There is another case-mix classifier for which the beneficiary qualifies, the contractor shall pay the claim according to the correct case-mix classifier calculated using the MDS QC System Software for all covered days associated with that MDS, and recoup any overpayments as necessary.									
11520.24	Contractors shall, if the reviewer determines that the beneficiary falls to a non-skilled level of care at some point during the period under review, deny the claim from the date on which the beneficiary no longer meets level of care criteria. Note: A partial denial is defined as either the disallowance of specific days within the stay or reclassification into a lower case-mix classifier.	X								CERT, RAC, SMRC, UPICs
11520.25	Contractors shall make partial denials based on classification into a new case-mix classification code or a full denial because the level of care requirement was not met are considered reasonable and necessary denials (per Social Security Act, title 18, section1862(a)(1)(A)) and are subject to appeal rights. Note: It is important to recognize the possibility that the necessity of some services could be questioned and yet not impact the case-mix classification. The case-mix classification may not change because there are many clinical conditions and treatment regimens that qualify the beneficiary for the case-mix classifier to which he or she was assigned.	X								CERT, RAC, SMRC, UPICs
11520.26	Contractors who suspect fraudulent behavior, e.g., a pattern of intentional	X								CERT,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	reporting of inaccurate information for the purpose of payment or the billing for services which were not furnished or who have quality of care concerns, shall refer the provider to the appropriate entity for further investigation.									RAC, SMRC, UPICs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jill Nicolaisen, 410-786-5873 or Jill.Nicolaisen@cms.hhs.gov , Jennifer Phillips, 410-786-1023 or Jennifer.Phillips@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services

Table of Contents
(Rev.924, Issued: 11-15-19)

Transmittals for Chapter 6

6.1 – Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) *Claims*

(*Rev. 924; Issued: 11-15-19; Effective: 10-01-19; Implementation: 12-17-19*)

In 1998, Medicare began paying skilled nursing facilities (SNFs) under a Prospective Payment System (PPS). PPS payments are per diem rates based on the patient's condition *and* determined *through a CMS prescribed case-mix model and payment classification system.* This classification is done by the use of a clinical assessment tool, the Minimum Data Set (MDS), and is required to be performed periodically according to an established schedule for purposes of Medicare payment. Each MDS represents the patient's clinical status based on an Assessment Reference Date (ARD) and established look-back periods for the covered days associated with that MDS. Medicare expects to pay at the rate based on the most recent clinical assessment (i.e., MDS), for all covered days associated with that MDS. Medical review decisions are based on documentation provided to support *the coding and* medical necessity of services recorded on the MDS for the claim period billed. *Medicare contractors focus on the unique, individualized needs, characteristics and goals of each patient, in conjunction with CMS payment policies, to determine the appropriateness of the case-mix classifier billed.*

All Medicare contractors are to review, *in accordance with their medical review strategies*, SNF PPS *services covered by the consolidated billing policy. SNF services excluded from consolidated billing are* identified in §4432(a) of the BBA and regular updates which can be accessed by contractors at: http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.

"Rules of thumb" in the Medical Review (MR) process are prohibited. Medicare contractors must not make denial decisions solely on the reviewer's general inferences about beneficiaries with similar diagnoses or on general data related to utilization. Any "rules of thumb" that would declare a claim not covered solely on the basis of elements, including but not limited to, lack of restoration potential, ability to walk a certain number of feet, or degree of stability, is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary's total condition and individual need for care.

The goal of medical review is to determine whether the services are reasonable and necessary, delivered in the appropriate setting, and coded correctly, based on appropriate documentation. Under PPS, beneficiaries must continue to meet the regular eligibility requirements for a SNF stay as described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §*§*20*ff*, such as the 3-day medically necessary hospital stay and admission to a participating SNF within a specified time period (generally 30 days) after discharge from the hospital.

6.1.1 - Skilled Nursing Facility Qualifying Inpatient Stay

(*Rev. 924; Issued: 11-15-19; Effective: 10-01-19; Implementation: 12-17-19*)

Under the SNF PPS, beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay are *presumed* to meet the level of care requirements of 42 CFR 409.31 up to and including the assessment reference date (ARD) for *the initial Medicare assessment (commonly referred to as the "*5-day*"* assessment*)* prescribed in 42 CFR 413.343(b), when correctly assigned to one of the *more intensive case-mix classifiers* that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. If the beneficiary is not admitted (or readmitted) directly to a SNF after a qualifying hospital stay, the administrative level of care presumption does not apply. *For a* further explanation of the administrative presumption of coverage, *please refer to §6.1.4 of this chapter, and to Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1 (including item 3 of that section for a discussion of a rehospitalization that exceeds the 3-day interruption window specified under the SNF PPS's interrupted stay policy)*.

Medicare contractors shall:

- Use the Common Working File (CWF) to validate the presence of an inpatient hospital claim that was paid by Medicare. Because the entire medical record from the inpatient hospital stay is not received for a SNF claim, it is difficult to determine if the medical record and the CWF conflict. Therefore, it is assumed that the dates of service for the inpatient hospital claim in CWF are correct for purposes of establishing the 3-day prior inpatient hospital claim dates. If the CWF is silent as to an associated 3-day inpatient hospital claim, confirm that the beneficiary had a 3-day inpatient hospitalization outside the Medicare system (for example, the Veteran's Administration hospital system). If such is the case, the medical record from the inpatient hospitalization can be used to establish inpatient hospitalization dates. This documentation need not be signed for this purpose.

- Presume medical necessity of the qualifying inpatient hospitalization. If, during the normal claims review process, evidence that the hospitalization may not have been medically necessary emerges, the Medicare contractors shall fully develop the case in accordance with the directions contained in Pub. 100-02, chapter 8, § 20 and 20.1.

- Verify that the extended care services were for an ongoing condition that was also present during the prior hospital stay (even if not the main reason for that stay), or for a new condition that arose while the beneficiary was receiving treatment in the SNF for the ongoing condition. In this context, the ongoing condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay. The Medicare contractors may use a hospital discharge summary or any additional documentation from the inpatient hospital to make this verification. This documentation need not be signed for this purpose.

6.1.2 - Types of SNF PPS Review

(*Rev. 924; Issued: 11-15-19; Effective: 10-01-19; Implementation: 12-17-19*)

A. *Targeted Probe and Educate* Medical Review

Medicare Administrative Contractors (MACs) shall follow the instructions described in Chapter 3 of Pub. 100-08, the Medicare Program Integrity Manual, when conducting medical review.

B. Demand Bills

MACs must conduct MR of all patient-generated demand bills with the following exception:

Demand bills for services to beneficiaries who are not entitled to Medicare or do not meet eligibility requirements for payment of SNF benefits (i.e., no qualifying hospital stay) do not require MR. A denial notice with the appropriate reasons for denial must be sent.

Demand bills are bills submitted by the SNF at the beneficiary's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and requests that the bill be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. The SNF must have the proper liability notice consistent with Section 1879 of the Social Security Act signed by the beneficiary unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative, or other authorized representative may make the request (see 42 CFR 424.36, Signature requirements). In the case where all covered services are being terminated, the SNF provider is also required to have issued an expedited determinations notice, as detailed in Pub. 100-04, Medicare Claims Processing Manual, chapter 30, section 260, and on the CMS website at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.html*.

When determining eligibility for Medicare coverage, the *MAC* shall review the demand bill and the medical record to determine that both technical and clinical criteria are met. If all technical and clinical criteria are met, and the reviewer determines that some or all services provided were reasonable and necessary, use the MDS QC System Software, as necessary, to determine the appropriate *case-mix classifier*. Further instruction on the use of this software for adjustment of SNF claims is found in section 6.1.3 below. If the reviewer determines that no services provided were medically necessary, the *MAC* shall deny the claim in full.

The *Health Insurance Prospective Payment System (*HIPPS*)* code and revenue code 0022 must be present on the demand bill. There may be cases where the *MAC* receives a demand bill for which no associated MDS (or other required Medicare assessment) was transmitted to the repository because the provider did not feel that the services were appropriate for Medicare payment. In these cases, if the Medicare contractor determines that coverage criteria are met (see § 6.1.*4* B.), and medically necessary skilled services were provided, the Medicare contractor shall pay the claim at the default rate for the period of covered care for which there is no associated MDS in the repository.

C. *Claims* Submitted for Medicare Denial Notices

Providers may submit *claims* for a denial from Medicare for Medicaid or another insurer that requires a Medicare denial notice. These *claims* are identified by condition code 21. The SNF is required to issue a notice of noncoverage to the beneficiary that includes the specific reasons the services were determined to be noncovered. A copy of this notice must be maintained on file by the SNF in case the Medicare contractor requests a copy of the notice. See Pub. 100-04, Medicare Claims Processing Manual, chapter 1, §60.1.3 for further details.

6.1.3 - *Claim* Review Requirements

(*Rev. 924; Issued: 11-15-19; Effective: 10-01-19; Implementation: 12-17-19*)

Medicare contractors must conduct review of SNF PPS *claims* in accordance with these instructions and all applicable Pub. 100-08, Medicare Program Integrity Manual sections, including but not limited to, Medicare contractor standard operating procedures for soliciting additional documentation, time limitations for receipt of the solicited documentation, claim adjudication, and recoupment of overpayment. Minimum requirements of a valid SNF PPS *claim* are:

- Revenue Code 0022 must be on the *claim*. This is the code that designates SNF PPS billing.

- A HIPPS code must also be on the *claim*. This is a five-character code. *The first character represents the patient's physical therapy (PT) component and occupational therapy (OT)* component classification. The second character represents the patient's speech-language *pathology (SLP) component classification. The third character represents the patient's nursing component classification. The fourth character represents the patient's non-therapy ancillary (NTA) component classification. The fifth character represents the assessment indicator (AI) code.* See Pub. 100-04, chapter 6, §30.1 for valid codes and assessment indicators.

6.1.4 - *Medical* Review Process

(*Rev. 924, Issued: 11-15-19; Effective: 10-01-19; Implementation: 12-17-19*)

A. Obtain *Medical* Records *and MDS*

Medicare contractors shall obtain documentation necessary to make a MR determination. Medical records must be requested from the provider and the MDS data must be obtained from the national repository. Medicare contractors are to use the MDS as part of the medical documentation used to

determine whether the HIPPS codes billed were accurate and appropriate. Medicare contractors shall use *the QIES (Quality Improvement & Evaluation System) Business Intelligence Center (QBIC) Fiscal Intermediary (FI) Extract Reports to obtain the MDS data from the National Reporting repository.*

Additional information about the use of the FI *E*xtract *Reports* can be found in the *QBIC* User's Guide.

Information (QBIC documentation & training) can be found at https://qtso.cms.gov. (Search for 'QBIC' when accessing the webpage.) Once the clinical reviewer has utilized the FI Extract *Reports* to obtain the MDS(es) corresponding to the period being reviewed, the reviewer will import the MDS data into the MDS QC Software System to convert it into a readable format to be used, in conjunction with review of the medical record, for the adjustment of the SNF claim.

Once the clinical reviewer has used the FI Extract Tool to obtain the MDS corresponding to the period being reviewed, the reviewer will import the MDS QC Software System to convert it into a readable format to be used, in conjunction with review of the medical record for the adjustment of the SNF claim. The MDS QC System Software and Reference Manual can be requested at MDSQC@nerdvana.fu.com. The MDS QC Tool contractor will contact CMS for approval of the request prior to sending out the MDS QC System Software and Reference Manual by FedEx.

Medicare contractors shall also request documentation to support the HIPPS code(s) billed, including notes related to the ARD, documentation relating to the look-back periods which may fall outside the billing period under review, and documentation related to the claim period billed. Since the ARD for each MDS marks the end of the look-back period (which may extend back 30 days), the Medicare contractor must be sure to obtain supporting documentation for up to 30 days prior to the ARD if applicable. The requested documentation may include hospital discharge summaries and transfer forms; physician orders and progress notes; patient care plans; nursing and rehabilitation therapy notes; and treatment and flow charts and vital sign records, weight charts and medication records.

Clinical documentation that supports medical necessity may be expected to include: physician orders for care and treatments, medical diagnoses, rehabilitation diagnosis (as appropriate), past medical history, progress notes that describe the beneficiary's response to treatments and his*/her* physical/mental status, lab and other test results, and other documentation supporting the beneficiary's need for the skilled services being provided in the SNF.

During the review process, if the provider fails to respond to a Medicare contractor's Additional Documentation Request (ADR) within the prescribed time frame, the Medicare contractor shall deny the claim. See Pub. 100-08, Medicare Program Integrity Manual, chapter 3, section *3.2.3.8* for information on denials based on non-response to

ADRs and section *3.2.3.9* for handling of late documentation. If the provider furnishes documentation that is incomplete/insufficient to support medical necessity, adjust the bill in accordance with §1862(a)(1)(A) of the Act.

B. Make a Coverage Determination

For all selected claims, the Medicare contractor shall review medical documentation and determine whether the following criteria are met, in order to make a payment determination:

- *The services must not be statutorily excluded--Determine whether the services are excluded from coverage under any provision in §1862(a) of the Act other than §1862(a)(1)(A).*

- MDS must have been transmitted to the state repository - The Medicare contractor shall

require that the provider submit the claim with the *case-mix classifiers* obtained from the "Grouper" software, as instructed in Pub. 100-04, Medicare Claims Processing Manual, chapter 6, § 30.1. Claims for which MDSs have not been transmitted to the repository should therefore not be submitted to Medicare for payment, and shall be denied. An exception to that instruction occurs in the case where the beneficiary is discharged or dies on or before day 8 of the SNF admission or readmission, as described in *Chapter 2 of the MDS 3.0 RAI manual*. In that specific case, Medicare contractors shall pay claims at the default rate, provided that level of care criteria were met and skilled services were provided and were reasonable and necessary. In all other cases, the Medicare contractor shall deny any claim for which the associated MDS is not in the repository.

- SNF must have complied with the assessment schedule - In accordance with 42 CFR §413.343, *in those instances when the assessment is not completed timely, the contractor shall pay at the default rate for any days of care prior to the assessment reference date of the required assessment.*

  The Interim Payment Assessment (IPA) is an optional assessment that providers may complete to report a change in the patient's classification. If an IPA has been completed, medical reviewer will examine the medical documentation as described in this section.

- *Services are Reasonable and Necessary--Determine whether the services are reasonable and necessary under §1862(a)(1)(A) of the Act. When making reasonable and necessary determinations, contractors shall determine whether the services indicated on the MDS were rendered and were reasonable and necessary for the beneficiary's condition as reflected by medical record documentation. If the reviewer determines that none of the services provided were reasonable and necessary or that none of the services billed were supported by the medical record as having been provided, the Medicare contractor shall deny the claim in full.*

- Level of care requirement must be met--Determine whether the services met the requirements according to 42 CFR §409.31.

  - Under PPS, the beneficiary must meet level of care requirements as defined in 42 CFR §409.31. *The SNF PPS includes an administrative presumption in which a beneficiary who is correctly assigned one of the designated case-mix classifiers on the initial Medicare ("5-day") PPS assessment is presumed to meet the SNF level of care through the assessment reference date (ARD). This effectively creates a presumption of coverage for the period from the first day of the Medicare covered services up to, and including, the ARD for that assessment, which must be set for no later than the eighth day of the SNF stay. The 5-day assessment may trigger a presumption of coverage only when the SNF admission directly follows discharge from a prior qualifying hospital stay.* See Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1 for further explanation of the administrative presumption of coverage.

  - *In the case described above, where the administrative presumption of coverage exists, Medicare contractors shall review the claim and supporting medical information specifically to confirm the correctness of the case-mix classifier assignment that triggered the presumption. To determine if the beneficiary was correctly assigned to a case-mix classifier, Medicare contractors shall verify that the billed case-mix classifier is supported by the associated provider documentation. Medicare contractors shall consider all available information in determining coverage. This includes the MDS, the medical records including physician, nursing, and therapy documentation, and the beneficiary's billing history.*

- A beneficiary who *is not assigned one of the case-mix classifiers* designated as representing the required level of care on the 5-day assessment prescribed in 42 CFR 413.343(b) IS NOT automatically classified as either meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures, so documentation must support that these beneficiaries meet the level of care requirements.

- For *days after the assessment reference date of the 5-day assessment,* determination of the continued need for, and receipt of, a skilled level of care will be based on the beneficiary's clinical status and skilled care needs for the dates of service under review.

- The level of care requirement includes the requirement that the beneficiary must require skilled nursing or skilled rehabilitation services, or both on a daily basis. Criteria and examples of skilled nursing and rehabilitation services, including overall management and evaluation of the care plan and observation of a patient's changing condition, may be found at 42 CFR §§409.32 and 409.33.

- An apparent interruption in daily skilled services should not be interpreted to signal an end to daily skilled care. Rather, consideration should be given to the provision of observation and assessment and management and evaluation of the care plan during the review of medical records.

C. Review Documentation and Enter Correct Data into the MDS QC Software When Appropriate.

If the reviewer determines that coverage criteria are met and services are not statutorily excluded, but some services provided were not reasonable and necessary or were not supported in the medical record as having been provided as billed, the current MDS QC System Software must be used to calculate appropriate payment. Medicare contractors shall pay claims according to the *case-mix classifier* value calculated using the MDS QC tool, regardless of whether it is higher or lower than the *case-mix classifier* billed by the provider. If none of the services provided were reasonable and necessary, the Medicare contractor shall deny the claim in full.

Medicare contractors shall use the most current version of MDS QC System Software to review and calculate appropriate payment for SNF claims. The medical reviewer will examine the medical documentation to make a determination as to whether it supports the data entered into the MDS assessment completed by the provider and extracted from the repository. If a discrepancy is noted, the reviewer shall enter the correct data reflected in the medical record, according to the instructions in the MDS QC System Software Reference Manual. The reviewer shall consider all available medical record documentation in entering data into the software. This includes physician, nursing, and therapy documentation, and the beneficiary's billing history. Review of the claim form alone does not provide sufficient information to make an accurate payment determination.

D. Outcome of Medical Record Review

*T*he Medicare contractor shall take action to pay the claim appropriately, for the days on which the SNF was in compliance with the assessment schedule (pay the default rate for the days on which the SNF provided covered care, but was not in compliance with the assessment schedule), as described in each of the following situations—

Services are Reasonable and Necessary as Documented on the MDS Submitted to the Repository:

- If no discrepancies are noted between the MDS submitted to the repository and the patient's medical record, during the relevant assessment period for the timeframe being billed, the Medicare

contractor shall verify that the *case-mix classifier* submitted on the claim matches the *case-mix classifier* on the MDS imported from the repository into the MDS QC tool, and:

- If the facility *case-mix classifier* obtained through the MDS QC tool matches the *case-mix classifier* submitted on the claim, the Medicare contractor shall pay the claim as billed for all covered days associated with that MDS, even if the level of therapy changed during the payment period.

- If the facility *case-mix classifier* obtained through the MDS QC tool DOES NOT match the *case-mix classifier* submitted on the claim*, the* Medicare contractor shall pay the claim at the appropriate level based on the *case-mix classifier level on the MDS* submitted to the repository (and subsequently obtained through the MDS QC tool) for all covered days associated with that MDS, even if the *services provided* changed during the payment period.

Some Services are Reasonable and Necessary but Not Supported as Billed in Patient Medical Record:

- If some *skilled* services were appropriate, but some services provided were not reasonable and necessary or were not supported by the medical record as having been provided as billed, and the reviewer determines (based on data entered from the medical record into the MDS QC System Software) that:

  - The discrepancies are such that they do not result in a change in the *case-mix classification* level as calculated by the MDS QC tool, during the relevant assessment period for the timeframe being billed, the Medicare contractor shall *accept* the claim as billed for all covered days associated with that MDS, even if the level of *skilled care* changed during the payment period.

  - There is another *case-mix classifier* for which the beneficiary qualifies, the Medicare contractor shall pay the claim according to the correct *case-mix classifier* calculated using the MDS QC System Software for all covered days associated with that MDS, and recoup any overpayments as necessary.

Need For Skilled Care Ends:

- *If the reviewer determines that the beneficiary falls to a non-skilled level of care at some point during the period under review, the Medicare contractor shall deny the claim from the date on which the beneficiary no longer meets level of care criteria.*

General Information for All HIPPS Codes

- No Skilled Care Needed or Provided--If the reviewer determines that none of the services furnished were reasonable and necessary and that no skilled care is needed or provided, the Medicare contractor shall deny the claim from the date that skilled care ended.

- Services Billed But Not Furnished--If the reviewer determines that any of the services billed were not furnished, deny the claim in part or full and, if applicable, the Medicare contractor shall apply the fraud and abuse guidelines in Pub 100-08, Medicare Program Integrity Manual, chapter 4.

A partial denial is defined as either the disallowance of specific days within the stay or reclassification into a lower *case-mix classifier*.

For any full or partial denials made, adjust the claim accordingly to recoup the overpayment. A partial denial based on classification into a new *case-mix classification* code or a full denial

because the level of care requirement was not met are considered reasonable and necessary denials (§1862(a)(1)(A)) and are subject to appeal rights.

It is important to recognize the possibility that the necessity of some services could be questioned and yet not impact the *case-mix* classification. The *case-mix* classification may not change because there are many clinical conditions and treatment regimens that qualify the beneficiary for the *case-mix classifier* to which he *or she* was *assigned*.

When reviewing bills, if the reviewer suspects fraudulent behavior, e.g., a pattern of intentional reporting of inaccurate information for the purpose of payment or the billing for services which were not furnished *or quality of care concerns*, it is the Medicare contractor's responsibility to *refer the provider to the appropriate entity for further investigation.*