| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 656** | **Date: June 15, 2016** |
| | **Change Request 9571** |

**Transmittal 651, dated May 27, 2016, is being rescinded and replaced by Transmittal 656 to include sections 6.1.1 through 6.1.5 the table in Section II, replace the reference to Transmittal 594 with Pub. 100-04, chapter 30, section 20 in section 6.1.2 B, correct the Provider Reimbursement Manual reference in section 6.1.4 B, and other minor edits that do not affect the policy. All other information remains the same.**

**SUBJECT: Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update chapter 6.1, Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills.

**EFFECTIVE DATE: June 28, 2016**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: June 28, 2016**

***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/Table of Contents |
| R | 6/6.1/Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills |
| R | 6/6.1.1/Skilled Nursing Facility Qualifying Inpatient Stay |
| R | 6/6.1.2/Types of SNF PPS Review |
| R | 6/6.1.3/Bill Review Requirements |
| R | 6/6.1.4/Bill Review Process |
| R | 6/6.1.5/Workload |

**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: 656 | Date: June 15, 2016 | Change Request: 9571 |
|---|---|---|---|

**Transmittal 651, dated May 27, 2016, is being rescinded and replaced by Transmittal 656 to include sections 6.1.1 through 6.1.5 the table in Section II, replace the reference to Transmittal 594 with Pub. 100-04, chapter 30, section 20 in section 6.1.2 B, correct the Provider Reimbursement Manual reference in section 6.1.4 B, and other minor edits that do not affect the policy. All other information remains the same.**

**SUBJECT: Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills**

**EFFECTIVE DATE: June 28, 2016**
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**IMPLEMENTATION DATE: June 28, 2016**

## I. GENERAL INFORMATION

**A. Background:** The Medical Review (MR) program is designed to prevent improper payments in the Medicare fee-for-service program. Whenever possible, MACs are encouraged to automate this process; however, it may require the evaluation of medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing policies.

**B. Policy:** The statutory authority for the MR program includes the following sections of the Social Security Act (the Act):

• Section 1833(e)

• Section 1842(a)(2)(B)

• Section 1862(a)(1)

• The remainder of Section 1862(a)

• Section 1893(b)(1)

• Sections 1812, 1861, and 1832

• Sections 1874, 1816, and 1842

The regulatory authority for the MR program rests in:

• 42 CFR 421.100

• 42 CFR 421.200

• 42 CFR 421.400

## II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 9571.1 | Medicare Contractors shall be aware that this CR updates Chapter 6.1 of the Program Integrity manual to the current Minimum Data Set (MDS). | X | | | | | | | | |
| 9571.2 | Medicare Contractors shall review to confirm that beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay have met the level of care requirements of 42 CFR 409.31. | X | | | | | | | | |
| 9571.3 | Medicare Contractors shall use the Common Working File (CWF) to validate the presence of an inpatient hospital claim that was paid by Medicare. | X | | | | | | | | |
| 9571.4 | Medicare Contractors shall presume medical necessity of the qualifying inpatient hospitalization. | X | | | | | | | | |
| 9571.5 | Medicare Contractors shall 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. | X | | | | | | | | |
| 9571.6 | Medicare Contractors shall use the MDS extract tool to obtain the MDS from the state repository for each billing period reviewed. | X | | | | | | | | |

## 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):** Della Johnson, della.johnson@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 MR Guidelines for Specific Services

**Table of Contents**
***(Rev. 656, Issued: 06-15-16)***

## 6.1 – Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills

***(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)***

Effective with cost reporting periods beginning on or after July 1, 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 as determined by classification into a specific Resource Utilization Group (RUG). 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. This means that the level of payment for each day of the SNF stay may not match exactly the level of services provided. Accordingly, the medical review process for SNF PPS bills must be consistent with the new payment process. The methodology for medical review of SNFs has changed under the PPS from a review of individualized services to a review of the beneficiary's clinical condition. Medical review decisions are based on documentation provided to support medical necessity of services recorded on the MDS for the claim period billed.

"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, such as, 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.

All *Medicare* contractors are to review, when indicated, Medicare SNF PPS bills, except for the excluded services 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.

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, 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. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)***

*Under the SNF PPS, beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay are considered to meet the level of care requirements of 42 CFR 409.31 up to and including the assessment reference date (ARD) for the 5-day assessment prescribed in 42 CFR 413.343(b), when correctly assigned to one of the Resource Utilization Groups (RUGs) 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. See Pub 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1 for further explanation of the administrative presumption of coverage.*

*Under PPS, the beneficiary must continue to meet level of care requirements as defined in 42 CFR 409.31. As noted above, CMS has established a policy that, when the initial Medicare required 5-day assessment results in a beneficiary being correctly assigned to one of the designated RUG groups, 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 may include grace days). This presumption does not arise in connection with any of the subsequent assessments, but applies specifically to the period ending with the ARD for the initial Medicare required 5-day assessment.*

*In the case described above, where the administrative presumption of coverage exists, Medicare contractors shall review the bill and supporting medical information specifically to confirm the correctness of the RUG assignment that triggered the presumption. This involves determining that the furnished services and intensity of those services, as defined by the billed RUG group, were reasonable and necessary for the beneficiary's condition. To determine if the beneficiary was correctly assigned to a RUG group, Medicare contractors shall verify that the billed RUG group 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.*

***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.*

*A beneficiary who groups into other than one of the RUGs 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.*

## 6.1.2 - *Types of SNF PPS Review*

***(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)***

*Medicare contractors shall no longer perform random postpayment reviews specific to SNF PPS bills. Instead, SNF PPS MR should be conducted on a targeted prepayment or postpayment basis. Consider the principles of Progressive Corrective Action (PCA) when conducting MR (see Pub. 100-08, Medicare Program Integrity*

*Manual, chapter 3, §3.11 for information on PCA). Medicare contractors are also required to continue to review 100% of SNF demand bills, from beneficiaries entitled to the SNF benefit. (See B below.)*

***A. Data Analysis and Targeted (Focused) Medical Review***

*Medicare contractors are to conduct targeted reviews, focusing on specific program vulnerabilities inherent in the PPS, as well as provider/service specific problems. The reviews should be conducted based on data analysis and prioritization of vulnerabilities.*

- *Data Analysis—Conduct data analysis to identify normal practice patterns, aberrancies, potential areas of overutilization, and patterns of non-covered care. Data analysis is the foundation for targeting medical review of claims. As described in Pub. 100-08, Medicare Program Integrity Manual, chapter 2, §2.2, data should be collected and analyzed from a variety of sources, including but not limited to SNF PPS billing information, data from other Federal sources (QIOs, Medicaid); and referrals from internal or external sources (e.g., provider audit, fraud and abuse units, beneficiary or other complaints) to ensure targeting and directing MR efforts on claims where there is the greatest risk of inappropriate program payment.*

- *Claim Selection--In selecting their overall workload, Medicare contractors may choose specific claims or target providers with high error rates, and must include newly participating providers.*

*Medicare contractors shall continue to track and report edit effectiveness through the standard activity reports.*

***B. Demand Bills***

*Medicare contractors 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 20, and on the CMS website at www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html (see "FFS ED").*

*When determining eligibility for Medicare coverage, the Medicare contractor 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 RUG code. 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 Medicare contractor shall deny the claim in full.*

*The HIPPS code and revenue code 0022 must be present on the demand bill. There may be cases where the Medicare contractor receives a demand bill for which no associated MDS (or other required Medicare*

*assessment) was transmitted to the state 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 § 6.1.3 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. If the 14-day state assessment has an ARD within the assessment window of either the Medicare 5-day or 14-day assessments, it may be used as a basis for billing the days associated with one of those Medicare-required assessments.*

### *C. Bills Submitted for Medicare Denial Notices*

*Providers may submit bills for a denial from Medicare for Medicaid or another insurer that requires a Medicare denial notice. These bills 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 - *Bill Review Requirements*

***(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)***

*Medicare contractors must conduct review of SNF PPS bills 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 bill are:*

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

*A Health Insurance Prospective Payment System (HIPPS) code must also be on the bill. This is a five-character code. The first three characters are an alpha/numeric code identifying the RUG classification. The last two characters are numeric indicators of the reason for the MDS assessment. See Pub. 100-04, chapter 6, §30.1 for valid RUG codes and assessment indicators.*

## 6.1.4 - *Bill Review Process*

***(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)***

### A. Obtain Records

*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 MDS extract tool to obtain the MDS from the state repository for each billing period reviewed.*

*Additional information about the use of the FI extract tool can be found in the User's Guide. The tool and guide can be found at https://web.qiesnet.org/qiesextract/. Once the clinical reviewer has utilized the FI Extract Tool 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.*

*The information below will be accurate for at least the next 5 years.*

*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 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 3.4.1.2 for information on denials based on non-response to ADRs and section 3.4.1.4 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.*

*During the review of demand bills, continue current prepayment or postpayment medical review operating procedures, as described above, if the provider fails to furnish solicited documentation within the prescribed time frames.*

***B. Make a Coverage Determination***

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

- ***MDS must have been transmitted to the state repository -*** *The Medicare contractor shall require that the provider submit the claim with the RUG code 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 state 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 Pub. 15-1, Provider Reimbursement Manual, chapter 28, §2833 D.1. 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 national repository.*

- ***SNF must have complied with the assessment schedule*** *- In accordance with 42 CFR §413.343, the contractor shall pay the default rate for the days of a patients care for which the SNF is not in compliance with the assessment schedule.*

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

  - *Under PPS, the beneficiary must meet level of care requirements as defined in 42 CFR §409.31. CMS has established a policy that, when the initial Medicare required 5-day assessment results in a beneficiary being correctly assigned to one of the RUGs designated as representing the required level of care, this 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 may include grace days).* ***This presumption does not arise in connection with any of the subsequent assessments****, but applies specifically to the period ending with the ARD for the initial Medicare required 5-day assessment. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1 for further explanation of the administrative presumption of coverage.*

*A beneficiary who groups into other than one of the RUGs 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 all assessments, other than the initial 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.*

- ***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).*

- ***Services are Reasonable and Necessary****--Determine whether the services are reasonable and necessary under §1862(a)(1)(A) of the Act. In making a reasonable and necessary determination, you must 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.*

*If the reviewer determines that some of the services were not reasonable and necessary, follow the instructions in the following subsection to utilize the current MDS QC System Software to calculate the appropriate RUG code and pay the claim according to the calculated code for all covered days associated with the MDS.*

***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 RUG value calculated using the MDS QC tool, regardless of whether it is higher or lower than the RUG 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 state 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***

*Once the Medicare contractor has:*

1. *obtained the medical record and electronic MDS submitted to the state by the provider;*

2. *determined whether coverage criteria are met;*

3. *reviewed the medical record, to determine whether services were reasonable and necessary and provided as billed; and*

4. *entered correct data into the MDS QC tool when discrepancies were noted, the 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:*

- *When the HIPPS Code Indicates Classification into a Rehabilitation Group and:*

  - *Rehabilitation Services are Reasonable and Necessary As Documented on the MDS Submitted to the State Repository: **If no** discrepancies are noted between the MDS submitted to the state repository and the patient's medical record, during the relevant assessment period for the timeframe being billed, the Medicare contractor shall verify that the RUG code submitted on the claim matches the RUG code on the MDS imported from the national repository into the MDS QC tool, and:*

    - *If the facility RUG value obtained through the MDS QC tool matches the RUG code 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 (e.g., O.T. is discontinued while medically necessary skilled P.T. services continue).*

    - *If the facility RUG value obtained through the MDS QC tool **DOES NOT** match the RUG code submitted on the claim:*

- *For example, when the resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) changes to such a degree that it would no longer reflect the correct RUG classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment, a PPS Unscheduled Assessment may be required to be completed. See the Resident Assessment Instrument (RAI) Manual, chapter 2, and section 2.9. The Medicare contractor shall pay the claim at the appropriate level based on the RUG code on the unscheduled PPS assessment submitted to the state repository (and subsequently obtained through the MDS QC tool) for all covered days associated with that MDS, even if the level of therapy changed during the payment period.*

- *Some Rehabilitation Services are Reasonable and Necessary but Not **Supported as Billed by the Patient Medical Record:** If some rehabilitation 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 RUG level as calculated by the MDS QC tool, during the relevant assessment period for the timeframe being billed, 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.*

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

- ***Rehabilitation Services are Not Reasonable and Necessary**-- If all rehabilitation services are determined to be medically unnecessary during the time of the relevant assessment period for the timeframe being billed, but the Medicare contractor determines (based on data entered from the medical record into the MDS QC System Software,) that*

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

    - *There are no other skilled services indicated in the medical records, the Medicare contractor shall deny all days.*

- ***All Rehabilitation Services are Discontinued With No Other Medicare-Required Assessment (OMRA) and Other Skilled Services Provided**--If the provider discontinued all rehabilitation services at some point during the period under review but did not complete an OMRA as required by Medicare 8-10 days after therapy is discontinued, the Medicare contractor shall pay at the appropriate HIPPS code for the relevant assessment period for 8 days after the date the rehabilitation services were discontinued, then at the default rate for the remainder of the payment period, as long as skilled need remains.*

- ***All Rehabilitation Services are Discontinued With No Other Medicare-Required Assessment (OMRA) and No Other Skilled Services Provided**--If the provider discontinued all rehabilitation*

*services at some point during the period under review but did not complete an OMRA as required by Medicare 8-10 days after therapy is discontinued and no other skilled care is needed, the Medicare contractor shall deny the claim from the date that the rehabilitation services were discontinued.*

- ***All Rehabilitation Services Become Not Reasonable and Necessary or are No Longer Provided--Skilled Need Continues**-- If the Medicare contractor determines that all rehabilitation services are no longer reasonable and necessary, or documentation does not support that any further rehabilitation services were being provided, at some point during the covered days associated with that MDS, but that other medically necessary skilled services were being provided, the Medicare contractor shall determine (based on data entered from the medical record into the current MDS QC System Software, whether there is a clinical group for which the beneficiary qualifies, and pay the claim according to the correct RUG value calculated using the MDS QC System Software, for all covered days associated with that MDS, from the date that the rehabilitation services are determined to be not reasonable and necessary or not provided, and recoup any overpayments as necessary.*

- ***All Rehabilitation Services Become Not Reasonable and Necessary--No Skilled Need Continues**-- If the Medicare contractor determines that rehabilitation services are no longer reasonable and necessary, or documentation does not support that any further rehabilitation services were being provided, at some point during the payment period and that no other skilled services are being provided, the Medicare contractor shall deny the claim from the date that the rehabilitation services are determined to be not reasonable and necessary.*

- *When the HIPPS Code Indicates Classification into a Clinical Group and:*

  - ***Services are Reasonable and Necessary As Documented on the MDS Submitted to the State Repository -** If no discrepancies are noted between the MDS submitted to the state repository and the patient's medical record, during the relevant assessment period for the timeframe being billed, the Medicare contractor shall verify that the RUG code submitted on the claim matches the RUG code on the MDS imported from the national repository into the MDS QC tool, and:*

    - *If the facility RUG value obtained through the MDS QC tool matches the RUG code 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 RUG value obtained through the MDS QC tool **DOES NOT** match the RUG code submitted on the claim, the Medicare contractor shall pay the claim at the appropriate level based on the RUG level on the MDS submitted to the state repository (and subsequently obtained through the MDS QC tool) for all covered days associated with that MDS, even if the level of therapy changed during the payment period.*

  - ***Some Services 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 RUG 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 clinical RUG for which the beneficiary qualifies, the Medicare contractor shall pay the claim according to the correct RUG value 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 you determine that any of the services billed were not furnished, deny the claim in part or full and, if applicable, 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 RUG group.*

*For any full or partial denials made, adjust the claim accordingly to recoup the overpayment. A partial denial based on classification into a new RUG 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 RUG classification. The RUG classification may not change because there are many clinical conditions and treatment regimens that qualify the beneficiary for the RUG group to which he was classified. For instance, a beneficiary who classifies into the Special Care category because he is aphasic, is being tube fed and has a fever would continue to classify into this category even if there is no evidence of fever in the medical record. Although fever with tube feeding is a qualifier for classification into the Special Care category, so is tube feeding with aphasia.*

*When reviewing bills, if you suspect 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, it is your responsibility to comply with CMS's Fraud and Abuse guidelines (Pub 100-08, Medicare Program Integrity Manual, chapter 4.)*

## 6.1.5 - *Workload*

***(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)***

*All Medicare contractors must review some level of SNF PPS bills based on data analysis. These are complex reviews and should be reviewed by professionals, i.e., at a minimum, by LPNs. Workload projections are to be addressed through the annual Budget Performance Requirements process.*