Medicare Program Integrity Manual
Chapter 5 – Items and Services Having Special *DME* Review Considerations

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(Rev. 71, 04-09-04)

*5.*1 – Home Use of DME

(Rev. 71, 04-09-04)

Medicare law limits Part B payment for DME to items/supplies used (delivered) in the patient's home. For claims that show a nursing home or hospital address as the beneficiary's residence, or if the place of service code indicates that the beneficiary is an inpatient of a hospital or nursing home, DMERCs *and DMERC PSCs* develop for the date of admission and determine whether payment is possible. (See PIM Chapter 5, §*5.*4.) If a hospital is a participating hospital, an emergency hospital, or a hospital which meets the requirements of §1861(e)(l) of the Act, it **does not** qualify as the patient's home.

The following screening guides apply when the individual is in an SNF:

- Where an institution is classified as a participating SNF, an §1819(a)(1) institution, or where a SNF has a part classified as participating and a part classified as meeting §1819(a)(1) of the Act, it cannot be considered the individual's home;
- If an institution has a part which is participating or a part which meets §1819(a)(l), and a remaining part which does not meet §1819(a)(l), identify the part in which the patient was physically located during the use period. The institution may be considered the individual's home only if he/she was in the part which does not meet §1819(a)(l). See MCM §2312.l if an item of equipment is furnished or used outside the U.S.; or,
- If a DME rental start date coincides with the patient's discharge date from an institution not classified as a "home", DMERCs *and DMERC PSCs* pay for medically necessary DME.

These rules apply only to DME claims. Orthotic and prosthetic devices are not subject to the "home use" requirement for coverage and payment purposes.

*5.*1.1 – Physician Orders

(Rev. 71, 04-09-04)

The supplier for all Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) is required to keep on file a physician prescription (order). The treating physician must sign and date the order. A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary.

*5.*1.1.1 - Verbal Orders

(Rev. 71, 04-09-04)

Except as noted in Chapter 5 Section *5.*1.1.2.1, suppliers may dispense most items of DMEPOS based on a verbal order. This verbal dispensing order must include: a description of the item, the beneficiary's name, the physician's name and the start date of the order. Suppliers must maintain written documentation of the verbal order and this documentation must be available to the DMERC *or DMERC PSC* upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is noncovered, and the supplier must not submit a claim for the item to the DMERC *or DMERC PSC*.

For items that are dispensed based on a verbal order, the supplier must obtain a written order that meets the requirements of this section.

*5.*1.1.2 -Written Orders

(Rev. 71, 04-09-04)

Written orders are acceptable for all transactions involving DMEPOS. Written orders may take the form of a photocopy, facsimile image, electronically maintained, or original "pen-and-ink" document. (See Chapter 3, Section 3.4.1.1.B.)

All orders must clearly specify the start date of the order.

For items that are dispensed based on a verbal order, the supplier must obtain a written order that meets the requirements of this section.

If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need. (For example, an order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for 1 month or until the ulcer heals.)

The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number.

If the order is for a rented item or if the coverage criteria in a policy specify length of need, the order must include the length of need.

If the supply is a drug, the order must specify the name of the drug, concentration (if applicable), dosage, frequency of administration, and duration of infusion (if applicable).

Someone other than the physician may complete the detailed description of the item. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement.

If a supplier does not have a faxed, photocopied, electronic or pen & ink signed order in their records before they can submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied. If the item is one that requires a written order prior to delivery (see Section *5.*1.1.2.1), the claim will be denied as not meeting the benefit category. If the claim is for an item for which an order is required by statute (e.g., therapeutic shoes for diabetics, oral anticancer drugs, oral antiemetic drugs which are a replacement for intravenous antiemetic drugs), the claim will be denied as not meeting the benefit category and is therefore not appealable by the supplier (see MCM Section 12000 for more information on appeals). For all other items, if the supplier does not have an order that has been both signed and dated by the treating physician before billing the Medicare program, the item will be denied as not reasonable and necessary

If an item requires a *Certificate of Medical Necessity (*CMN*)* and the supplier does not have a faxed, photocopied, electronic, or pen & ink signed CMN in their records before they submit a claim to Medicare, the claim will be denied. If the CMN is used to verify that statutory benefit requirements have been met, then the claim will be denied as not meeting the benefit category. If the CMN is used to verify that medical necessity criteria have been met, the claim will be denied as not reasonable and necessary.

Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, limitations, etc.) is NOT in itself considered to be part of the order although it may be put on the same document as the order.

*5.*1.1.2.1 - Written Orders Prior to Delivery
(Rev. 71, 04-09-04)

A written order prior to delivery is required for: pressure reducing pads, mattress overlays, mattresses, and beds; seat lift mechanisms; TENS units; and power operated vehicles. DMERCs *and DMERC PSCs* may identify other items for which they will require a written order prior to delivery.

For these items, the supplier must have received a written order that has been both signed and dated by the treating physician and meets the requirements of Section *5.*1.1.2 before dispensing the item.

If a supplier bills for an item without a written order, when the supplier is required to have a written order prior to delivery, the item will be denied as not meeting the benefit category (see the MCM, Section 12000 for more information on appeals).

*5.*1.1.3 – Requirement of New Orders

(Rev. 71, 04-09-04)

A new order is required in the following situations:

- There is a change in the order for the accessory, supply, drug, etc.;
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy;
- When an item is replaced; and
- When there is a change in the supplier.
- In cases where two or more suppliers merge, the resultant supplier should make all reasonable attempts to secure copies of all active CMNs from the supplier(s) purchased. This document should be kept on file by the resultant supplier for future presentation to the DMERC *or DMERC PSC*.

*5.*1.1.4 - CMN as the Written Order

(Rev. 71, 04-09-04)

When reviewing claims where the medical record contains a copied, faxed or electronically maintained CMN (any CMN created, modified, and stored via electronic means such as commercially available software packages and servers), the DMERC *and DMERC PSC* must accept the copied, faxed or electronic document as fulfilling the requirements for these documents.

When a DMERC *or DMERC PSC* is investigating potentially fraudulent behavior by a supplier, it will be the supplier's responsibility to prove the authenticity/validity of the claim(s) under investigation. A DMERC *or DMERC PSC* may require the supplier to prove the authenticity/validity of the signature on the CMN or order, or any other questionable portion of the claim(s) under investigation.

Upon request by the DMERCs *and DMERC PSCs*, suppliers must provide the CMN, in a format that the DMERCs *and DMERC PSCs* can accept, in a timely manner. Upon medical review, the DMERCs *and DMERC PSCs* should not deny claims solely because the CMN is faxed, copied, or electronic. The DMERC *or DMERC PSC* may request the supplier to download and print a hard copy of an electronic order or CMN if the DMERC *or DMERC PSC* cannot access it electronically.

For items that require a CMN, and for accessories, supplies, and drugs related to an item requiring a CMN, the CMN may serve as the written order IF the narrative description in Section C is sufficiently detailed (as described above). This applies to both hard copy and electronic orders and CMNs.

A supplier must have a hard copied, faxed or electronic order or CMN in their records before they can submit a claim for payment to Medicare. Suppliers must ensure the security and integrity of electronically maintained CMNs are in accordance with any regulations published by *CMS*.

DMERCs *and DMERC PSCs* need not make any *shared* system changes to electronically accept e-CMNs as *CMS* views e-CMNs as a transaction between the physician and suppliers. Suppliers must continue to use current systems for transmitting claim information to the DMERC *or DMERC PSC*.

*5.*1.1.4.1 - Cover Letters for CMNs

(Rev. 71, 04-09-04)

Cover letters can be used by a supplier as a method of communication between the supplier and the physician. It is not *CMS*'s intent to restrict necessary communication between the supplier and the physician. *CMS* does not require nor regulate the cover letter. The DMERCs *and DMERC PSCs* should not take adverse action against suppliers that solely involve cover letters.

The DMERC *and DMERC PSCs* should regularly publish an article in their bulletins asking suppliers to remind physicians of their responsibility in completing and signing the CMN. It is the physician's responsibility to determine both the medical need for, and the utilization of, all health care services. The physician should ensure that information relating to the beneficiary's condition is correct. The DMERC *and DMERC PSCs* should encourage suppliers to include language in their cover letters to remind physicians of their responsibilities.

*5.*1.1.4.2 – Completing a CMN

(Rev. 71, 04-09-04)

The "Initial Date" found in Section A of the CMN, should be either the specific date that the physician gives as the start of the medical necessity or, if the physician does not give a specific start date, the "Initial Date" would be the date of the order.

The "Signature Date" is the date the physician signed and dated Section D of the CMN. This date might not be the same as the "Initial Date", since the "Signature Date" must indicate when the physician signed Section D of the CMN.

The "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or start date on the written order. To ensure that an item is still medically necessary, the delivery date/date of service must be within 3 months from the "Initial Date" of the CMN or 3 months from the date of the physician's signature.

The DMERCs *and DMERC PSCs* have the authority to request to verify the information on a CMN at any time. If the information contained either in the supplier's records or in the patient's medical record maintained by the ordering physician fails to substantiate the CMN, or if it appears that the CMN has been altered, the DMERCs *and DMERC PSCs* should consider the service not reasonable and necessary and initiate the appropriate administrative actions.

In the event of a post pay audit, the supplier must be able to produce the CMN and, if requested by the DMERC *or DMERC PSC*, produce information to substantiate the information on the CMN. If the supplier cannot produce this information, the DMERCs *and DMERC PSCs* should consider the service not reasonable and necessary, and initiate a denial or an overpayment action.

If there is a change made to any section of the CMN after the physician has completed Section B and signed Section D of the CMN, the physician must line through the correction, initial and date the correction; or the supplier may choose to have the physician complete a new CMN.

*5.*1.1.4.3– DMERCs' *and DMERC PSCs'* Authority to Assess an Overpayment and/or CMP When Invalid CMNs Are Identified *(Rev. 71, 04-09-04)*

Section 1862(a)(1)(A) of the Act prohibits Medicare payment for services that are not reasonable and necessary. Section 1833(e) of the Act requires that Medicare be furnished by providers and suppliers "such information as may be necessary in order to determine the amount due…." These sections provide support that a failure to have a valid CMN on file or to submit a valid CMN to the DMERC *or DMERC PSC* makes the underlying claim improper because Medicare does not have sufficient information to determine whether the claim is reasonable and necessary. A valid CMN is one in which the treating physician has attested to and signed supporting the medical need for the item, and the appropriate individuals have completed the medical portion of the CMN. When the DMERCs *and DMERC PSCs* identify a claim for which a CMN is not valid, they may deny the claim and/or initiate overpayment action.

If a DMERC or *DMERC PSC* identifies a supplier that has a pattern of improperly completing the CMN, the DMERC *or DMERC PSC* may choose to develop a potential Civil Monetary Penalty (CMP) case against the supplier. The authority for such action is found in §1834(j)(2)(A)(iii) of the Act which states that "any supplier of medical equipment and supplies who knowingly and willfully distributes a CMN in violation of clause (I) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed." The provisions of §1128A of the Act (other than subsections (a) and (b) shall apply to CMPs penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under §1128(A)(a)) of the Act.

*5.*1.1.5 - Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders

(Rev. 71, 04-09-04)

A nurse practitioner or clinical nurse specialist may give the dispensing order and sign the written order in the following situations:

- They are treating the beneficiary for the condition for which the item is needed;
- They are practicing independently of a physician;
- They bill Medicare for other covered services using their own provider number; and
- They are permitted to do all of the above in the state in which the services are rendered.

A nurse practitioner or clinical nurse specialist may complete Section B and sign Section D of a CMN if they meet all the criteria described above for signing orders.

*5.*1.1.6 - Physician Assistant Rules Concerning Orders and CMNs

(Rev. 71, 04-09-04)

Physician assistants may provide the dispensing order and write and sign the written order if they satisfy all the following requirements:

- They meet the definition of physician assistant found in §1861(aa)(5)(A) of the Act and §2156(A) of the Medicare Carriers Manual;
- They are treating the beneficiary for the condition for which the item is needed;
- They are practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy;
- They have their own UPIN; and
- They are permitted to perform services in accordance with State law.

Physician assistants may complete Section B and sign Section D of a CMN if they meet all the criteria described above for signing orders.

*5.*2 – Documentation in the Patient's Medical Record

(Rev. 71, 04-09-04)

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the

necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN, it is recommended that a copy of the completed CMN be kept in the patient's record. However, neither a physician's order nor a CMN nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or HHA records and records from other professionals including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.

The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DMERC *or DMERC PSC*. However, the DMERC *or DMERC PSC* may request this information in selected cases. If the DMERC *or DMERC PSC* does not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

*5.*2.1 - Supplier Documentation

(Rev. 71, 04-09-04)

Before submitting a claim to the DMERC *or DMERC PSC*, the supplier must have on file a dispensing order, the written order, the CMN (if applicable), information from the treating physician concerning the patient's diagnosis (if an ICD-9-CM code is required on the claim), and any information required for the use of specific modifiers or attestation statements as defined in certain DMERC *and DMERC PSC* policies. The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criterion for an item has been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained.

Documentation must be maintained in the supplier's files for seven (7) years.

Suppliers are required to maintain proof of delivery documentation in their files. The proof of delivery requirements are outlined below according to the method of delivery. The three methods of delivery are:

- Supplier delivering directly to the beneficiary or authorized representative;
- Supplier utilizing a delivery/shipping service to deliver items; and
- Delivery of items to a nursing facility on behalf of the beneficiary.

Proof of delivery documentation must be available to the DMERC *or DMERC PSC* on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for imposition of CMPs or Administrative Sanctions.

*5.*3 – Evidence of Medical Necessity

(Rev. 71, 04-09-04)

If replacement supplies are needed for the therapeutic use of purchased DMEPOS, the treating physician must specify on the prescription, or on the CMN, the type of supplies needed and the frequency with which they must be replaced, used, or consumed. DMERCs *and DMERC PSCs* evaluate supply utilization information as part of the medical necessity determination for DMEPOS. They do not accept "PRN" or "as needed" utilization estimates for supply replacement, use, or consumption.

Absent a State law to the contrary **or** a supply utilization problem, the prescription or physician's certification submitted for the DMEPOS may also serve as medical evidence for supply replacement claims. However, when a prescription for DMEPOS is renewed or revised, supply utilization information must be specified or updated by the physician on the CMN. DMERCs *and DMERC PSCs* assess the continuing medical necessity.

DMERCs *and DMERC PSCs* must establish procedures for monitoring the utilization of replacement supplies. DMERCs *and DMERC PSCs* must inform suppliers of the need to submit updated medical information if the patient's condition materially changes the equipment, device, or supply utilization requirements. Absent such notification, DMERCs *and DMERC PSCs* do not allow claims for unexplained increases in supply utilization above the usage level they previously determined as medically necessary. Suppliers must provide this information with the claim where indicated in published policy or to make it available to the DMERC *or DMERC PSC* on request.

If necessary or appropriate for a medical necessity determination, the DMERC *or DMERC PSC* must ask the supplier to obtain documentation from the treating physician, establishing the severity of the patient's condition and the immediate and long term need for the equipment and the therapeutic benefits the patient is expected to realize from its use. A claim of therapeutic effectiveness or benefit based on speculation or theory alone

cannot be accepted. When restoration of function is cited as a reason for use of DMEPOS, the exact nature of the deformity or medical problem should be clear from the medical evidence submitted. Also, the manner in which the equipment or device will restore or improve the bodily function should be explained by the treating physician.

If the DMERC *or DMERC PSC* is unsuccessful in obtaining medical information from the supplier for non-assigned claims, it gives the beneficiary the opportunity to obtain the desired information from the supplier. If, after obtaining the requested information, a question of medical necessity remains, the DMERC *or DMERC PSC* medical staff must resolve the issue.

*5.*3.1 – Period of Medical Necessity--Home Dialysis Equipment

(Rev. 71, 04-09-04)

The period of medical necessity for **home dialysis equipment** must be specified, e.g., "at least x months." Situations may occur causing temporary non-use of equipment:

- Beneficiary requires in-facility treatment for re-stabilization or as a result of some acute condition. The beneficiary is expected to return to home dialysis;
- Beneficiary is temporarily without a suitable home dialysis assistant;
- Beneficiary is away from home but expects to return; or
- Beneficiary is a transplant candidate and is taken off home dialysis preparatory to transplant. (If the transplant cannot occur, or if the transplant is not successful, the patient will very likely resume home dialysis and an evaluation can be made whether it will be within the immediate or foreseeable future.)

Under such circumstances, DMERCs *and DMERC PSCs* determine that medical necessity exists and pay for a period of up to 3 months after the month home dialysis equipment was last used. This does not eliminate the necessity for periodic reevaluation of medical necessity. It provides a tolerance to avoid frequent reevaluation in renal dialysis situations and provides for continuity of payments where economically advantageous.

*5.3.*2 – Safeguards in Making Monthly Payments

(Rev. 71, 04-09-04)

DMERCs *and DMERC PSCs* must establish appropriate safeguards to assure that payments are not made beyond the last month of medical necessity. They must develop appropriate safeguards to identify and investigate the following:

- Multiple claims for rental of the same or similar equipment from the same supplier within the same rental month (e.g., rental claims with different start dates but within the same rental period);
- Contraindicated items of rented or purchased equipment;
- Incompatible claims information (e.g., liquid oxygen contents billed for a purchased gas delivery system);
- Medical equipment rentals or purchases after a beneficiary's death;
- Rental start dates on or after the purchase of the same or comparable equipment (absent evidence that the beneficiary has disposed of purchased equipment);
- Rental claims for the same or similar equipment from different suppliers for the same or overlapping rental months; and
- Equipment rental start dates within periods of confinement in an institution that cannot be considered a patient's home.

DMERCs *and DMERC PSCs* must resolve these situations on a prepayment basis. Development, if necessary, may be via written or telephone contact per MCM §3311, subject to any other documentation or development guidelines specified in MCM §§4105ff.

To the extent possible, DMERCs *and DMERC PSCs* give beneficiaries and supplier-assignees advance notice of the date and reason that payments are scheduled to stop. (See MCM §§7012ff. for EOMB language.)

5.3.2.1 – Guidance on Safeguards in Making Monthly Payments

(Rev. 71, 04-09-04)

It is appropriate to develop safeguards against improper payment of claims. This section provides DMERCs *and DMERC PSCs* with additional guidance in creating and applying these safeguards to DME claims.

5.3.2.1.1 – Pick-up Slips

(Rev. 71, 04-09-04)

MCM §4105.2(B) specifically forbids payments for multiple claims for rental of the same or similar equipment from either the same or a different supplier during the same rental month.

For purposes of this section, a pick-up slip is written confirmation, provided by a supplier, that the supplier has removed an item of DME from the beneficiary’s home.

When making determinations, DMERCs *and DMERC PSCs* must ascertain not only whether equipment is present in the home, but must determine which equipment is actually being used by the patient. Therefore, it is inappropriate to determine, solely based on lack of a pick up slip, that a piece of equipment may still be in use. Likewise, it is inappropriate for DMERCs *and DMERC PSCs* to deny claims solely based on lack of a pick up slip. DMERCs *and DMERC PSCs* should develop these claims to determine which piece of equipment is medically necessary.

*5.*3.3 - Certificates of Medical Necessity

(Rev. 71, 04-09-04)

For certain items or services billed to a DMERC *or DMERC PSC*, the supplier must receive a signed CMN from the treating physician. A supplier must have a faxed or copied, original signed order or CMN in their records before they can submit a claim for payment to Medicare. CMNs communicate, either on paper or in an electronic record, required medical necessity information and have a DMERC *or DMERC PSC* form number (e.g., 01, 02, 03) and a revision number (e.g., .01, .02). Some DMERC *and DMERC PSC* forms also have an alpha suffix (e.g., A, B, C).

All CMNs have a *CMS* form number in addition to the DMERC *or DMERC PSC* form number. (See the following listing of CMN form numbers.) The *CMS* form number is in the bottom left corner of the form. CMNs are referred to by their *CMS* form numbers. DMERC *and DMERC PSC* form numbers identify the CMN on electronic claims submitted to the DMERC *and DMERC PSC* in the National Standard Format (NSF). *CMS* Form 484 serves as the CMN for home oxygen therapy.

A faxed, copied, an original hardcopy, or an electronic CMN must be maintained by the supplier and be available to the DMERCs *and DMERC PSCs* on request. When hardcopy CMNs are submitted to the DMERC *or DMERC PSC*, the supplier must include a copy of only the front side. When CMNs are submitted electronically to the DMERC *or DMERC PSC*, only information from sections A, B, and D are required since section C cannot be transmitted electronically. However, suppliers who bill electronically are not exempt from having section C completed on the original CMN.

The following is a list of the currently approved CMNs:

DMERC FORM	*CMS* FORM	ITEMS ADDRESSED
484.2	484	Home oxygen therapy
01.02A	841	Hospital beds
01.02B	842	Support surfaces
02.03A	843	Motorized wheelchairs

02.03B	844	Manual wheelchairs
04.03B	846	Lymphedema pumps (pneumatic compression devices)
04.03C	847	Osteogenesis stimulators
06.02B	848	Transcutaneous electrical nerve stimulators (TENS)
07.02A	849	Seat lift mechanisms
07.02B	850	Power operated vehicles
09.02	851	External Infusion Pumps
10.02A	852	Parenteral nutrition
10.02B	853	Enteral nutrition
11.01	854	Section C continuation (manual and motorized wheelchairs - ONLY)

The CMN sent to the physician must be two-sided with instructions on the back. If the CMN is mailed to the physician, the supplier must send the two-sided form. If the CMN is faxed, the supplier must fax both the front and back of the form. It is in the suppliers' interest to maintain a copy of what they faxed to the physician. Suppliers must maintain a copy of the completed CMN in their records. However, if the physician only faxes the front of the completed CMN then the supplier is only required to maintain the front portion of the CMN. Because these forms have been approved by the Office of Management and Budget (OMB), when a CMN is submitted with a paper claim, the hard copy must be an exact reproduction of the *CMS* form.

However, when the CMN is submitted electronically and the supplier chooses to maintain a hard copy CMN, the font may be modified as follows:

- *P*itch may vary from 10 characters per inch (cpi) to 17.7 cpi;
- Line spacing must be 6 lines per inch;
- Each CMN must have a minimum 1/4 inch margin on all four sides;

Without exception, these modified hard copy forms must contain identical questions/wording to the *CMS* forms, in the same sequence, with the same pagination, and identical instructions/definitions printed on the back; and

CMN question sets may not be combined.

The CMN can serve as the physician's order if the narrative description is sufficiently detailed. This would include quantities needed and frequency of replacement on accessories, supplies, nutrients, and drugs. For items requiring a written order prior to delivery (decubitis care items, TENS, POVs, seat lift mechanisms), suppliers may utilize a completed and physician-signed CMN for this purpose. Otherwise, a separate order in addition to a subsequently completed and signed CMN is necessary.

The supplier may not complete the information in section B of the CMN. A supplier who knowingly and willfully completes section B of the form is subject to a civil monetary penalty up to $1,000 for each form or document so distributed. Any supplier who remains in non-compliance after repeated attempts by the contractor to get the supplier into compliance, refer to your RO *(for PSCs, the GTL, Co-GTL, and SME)* as a potential civil monetary penalty case.

The information in section C of the CMN (fee schedule amount, narrative description of the items furnished and the supplier's charge for the medical equipment or supplies being furnished) must be completed on the form by the supplier prior to it being furnished to the physician. A supplier who knowingly and willfully fails to include this information may be subject to a civil monetary penalty up to $1,000 for each form or document so distributed. Any supplier who remains in non-compliance, after repeated attempts by the contractor to get the supplier into compliance, refer to your RO *(for PSCs, the GTL, Co-GTL, and SME)* as a potential civil monetary penalty case.

Do not modify the language or content when reprinted. Also, do not accept any CMN that has been modified in any way by any other party. In addition, do not accept any other certifications of medical necessity by other insurers or government agencies.

Suppliers and physician may choose to utilize electronic CMNs (e-CMN). E-CMNs must adhere to all privacy, security, and electronic signature rules and regulations promulgated by *CMS* and DHHS. Additionally, e-CMNs must contain identical questions/wording to the *CMS* forms, in the same sequence, with the same pagination, and identical instructions/definitions as printed on the back of the hardcopy form.

5.3.3.1 – Acceptability of Faxed Orders and Facsimile or Electronic Certificates of Medical Necessity

(Rev. 71, 04-09-04)

When reviewing claims and orders or auditing CMNs for DMEPOS, DMERCs *and DMERC PSCs* may encounter faxed, copied, or electronic orders and CMNs in supplier files. Generally, DMERCs *and DMERC PSCs* should accept these documents as fulfilling the requirements for these documents.

The DMERCs *and DMERC PSCs* retain the authority to request additional documentation to support the claim. If a DMERC *or DMERC PSC* finds indications of potential fraud or misrepresentation of these documents, or the claims submitted, they should refer the matter to the Benefit Integrity unit for development.

5.4 – Incurred Expenses for DME and Orthotic and Prosthetic Devices

(Rev. 71, 04-09-04)

The first month's expense for rental is incurred on the date of delivery of the equipment. Expenses for subsequent months are incurred on the same date of the month. Where equipment is purchased, benefits are payable on the same basis. Suppliers may submit claims as of the date expenses are incurred. If the date of delivery is not specified on the claim, reviewers assume, in the absence of evidence to the contrary, that the date of purchase or rental was the date of delivery.

Generally, for all DMEPOS, the supplier's date of service (DOS) is the date of delivery to a beneficiary's home. For DMEPOS provided to a beneficiary immediately following a hospital inpatient stay and/or DME immediately following a nursing home stay, the DOS is the date of final discharge to the beneficiary's home. For mail order DMEPOS provided immediately subsequent to a hospital inpatient stay and/or DME immediately following a nursing home stay, the DOS is the latter of the actual delivery date or the date of the discharge. Under no circumstances can the DOS be earlier than the date of delivery.

No payment may be made for rental for any month throughout which the patient is in an institution that does not qualify as his or her home (see MCM §2100.3) or is outside the U.S. (See MCM §2312.) If the patient is at home as of the first day of a rental month and, for part of the same rental month, is in an institution which cannot qualify as his or her home, or is outside the U.S., payment may be made for the entire rental month. Similarly, if an item of **rental** equipment is returned to the supplier before the end of a payment month because the beneficiary died in that rental month or because the equipment became unnecessary in that month, payment may be made for the entire rental month. However, if the supplier charges for only part of a month, or the DMERC *or DMERC PSC* is aware that the supplier customarily follows such a practice, it pays on a prorated basis. If the individual is outside the U.S. for more than 30 days and returns to the U.S. (before resuming payments), it determines medical necessity as in an initial case.

Note that in the case of purchased equipment, MCM §2312 requires that the beneficiary must have been in the United States when the item was delivered, and MCM §1050 requires that the individual must have had Supplementary Medical Insurance (SMI) coverage at the time the item was delivered. Therefore, where a purchased item of equipment was delivered to an individual outside the United States or before his/her coverage period began (i.e., the effective date of his/her enrollment), the entire expense of the item is excluded from coverage whether it was paid for in its entirety at purchase or on a deferred or installment basis. Payment cannot be made in such cases even though the individual uses the item inside the United States or after his/her coverage begins.

Contractor systems must maintain the outcome (e.g., audit trail) of prepayment decisions such as approved, denied, or partially denied.

*5.*5 – Patient Equipment Payments Exceed Deductible and Coinsurance on Assigned Claims

(Rev. 71, 04-09-04)

DMERCs *and DMERC PSC* pay the patient under the procedure described in MCM §7057 where the patient's payments on an assigned claim exceed the deductible and coinsurance applicable to the allowed charges.

They pay benefits to the supplier first. After the supplier has been paid, DMERCs *and DMERC PSCs* pay the beneficiary so that the payments to the supplier plus the amount paid by the beneficiary equal the fee schedule for the purchase of the equipment. The patient is paid according to the amount by which the deductible and coinsurance were overpaid.

The supplier may prefer to delay charging the beneficiary until the amount of deductible and coinsurance are known. Any payments which have been made, however, should be shown in Item 29 of the Form *CMS*-1500 or Item 10 of the Form *CMS*-1490.

*5.*6 – Evidence of Medical Necessity - Oxygen Claims

(Rev. 71, 04-09-04)

If DMERCs *and DMERC PSCs* learn that the physician of record is no longer the treating physician, the supplier must be directed to obtain from the physician currently responsible for the patient's pulmonary condition a current, fully completed CMN. After review of this CMN, DMERCs *and DMERC PSCs* continue monthly payments if the evidence establishes medical necessity. Their records must be updated to identify the new treating physician and, if necessary, adjust the schedule for further re-certifications.

*5.*7 – Advance Determination of Medicare Coverage (ADMC) of Customized DME

(Rev. 71, 04-09-04)

Section 1834(a)(15)(C) of the Act provides that carriers shall, at the request of a supplier or beneficiary, determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered if:

- The item is a customized item,
- The patient to whom the item is to be furnished, or the supplier, requests that such advance determination be made, and
- The item is not an inexpensive item as specified by the Secretary.

This section provides for direction in implementing § 1834 (a)(15)(C) of the Act.

It is important to note that ADMCs are not initial determinations as defined at 42 CFR 405.801(a), because no request for payment is being made. As such, an ADMC cannot be appealed.

This is a voluntary program. Beneficiaries and suppliers are not required to submit ADMC requests in order to submit claims for items. Additionally, DMERCs *and DMERC PSCs* may not require an ADMC request as a prerequisite for submitting a claim.

*5.*7.1 – Definitions

(Rev. 71, 04-09-04)

*5.*7.1.1 – Definitions of Customized DME

(Rev. 71, 04-09-04)

Section 1834(a)(4) of the Act and 42 CFR 414.224 define customized DME as being items of DME which have been **uniquely constructed or substantially modified** for a specific beneficiary according to the description and orders of the beneficiary's treating physician.

For instance, a wheelchair which has been (1) measured, fitted, or adapted in consideration of the patient's body size, disability, period of need, or intended use, (2) assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs, and (3) is intended for an individual patient's use in accordance with instructions from the patient's physician would be considered “customized".

*5.*7.2 – Items Eligible for ADMCs

(Rev. 71, 04-09-04)

Effective September 1, 2001 the DMERCs *and DMERC PSCs* will no longer provide prior authorization for transcutaneous electrical nerve stimulators, seat lift mechanisms or power operated vehicles.

The DMERCs *and DMERC PSCs* shall publish examples of the types of items for which ADMCs are available. These examples shall be published yearly in the DMERC's *and DMERC PSC's* Suppliers' Bulletin. Examples will be published in the form of HCPCS codes eligible for this program. Because HCPCS codes describe general “categories" of equipment, this list is not a list of specific items, but rather a general list of the categories of types of items eligible for this program.

*5.*7.3 – Instructions for Submitting ADMC Requests

(Rev. 71, 04-09-04)

Beginning October 1, 2001, at their option, suppliers or beneficiaries may submit, in hard copy, requests for ADMC. Requests must contain adequate information from the patient's medical record to identify the patient for whom the item is intended, the intended use of the item, and the medical condition of the patient that necessitates the use of a customized item.

Each DMERC *and DMERC PSC* shall publish the mailing address to which requests should be sent.

*5.*7.4 – Instructions for Processing ADMC Requests

(Rev. 71, 04-09-04)

Once a requst is received, the DMERC *or DMERC PSC* shall determine if there is sufficient medical documentation that supports whether the item is reasonable and necessary. In addition, a review of the beneficiary's claims' history should be conducted in order to determine whether any other reason exists to cause the claim to be denied, e.g., whether the same or similar equipment has already been provided.

Upon receipt of a request, the DMERC *or DMERC PSC* shall render an advance determination of Medicare coverage within 30 calendar days. DMERCs *and DMERC PSCs* shall provide the requestor with their decision, be it affirmative or negative, in writing.

If requests are received for the wrong item(s), the request will be rejected. Rejected requests should not be counted as workload.

Requests for appropriate items received without documentation to support coverage will be denied as not meeting the medical necessity requirements Medicare has established for the item.

*5.*7.5 – Affirmative ADMC Decisions

(Rev. 71, 04-09-04)

When making an ADMC, the DMERC *or DMERC PSC* should review the information submitted with the request to determine; 1) if a benefit category exists, 2) if a statutory exclusion exists, and 3) if the item is reasonable and necessary.

An affirmative ADMC decision will provide the supplier and the beneficiary assurance that the beneficiary, based on the information submitted with the request, will meet the medical necessity requirements Medicare has established for the item. An affirmative ADMC decision does not provide assurance that the beneficiary meets Medicare

eligibility requirements nor does it assure that any other Medicare requirements (MSP, etc.) have been met. Only upon submission of a complete claim, can the DMERC *or DMERC PSC* make a full and complete determination.

An affirmative ADMC decision does not extend to the **price** that Medicare will pay for the item.

An affirmative ADMC decision is valid for a period of 6 months from the date the decision is rendered. Oftentimes, beneficiaries who require customized DME are subject to rapid changes in medical condition. These changes may obviate the need for a particular item, either because the beneficiary's condition improved or deteriorated. For this reason, the date the item was provided to the beneficiary cannot be more than 6 months after the date the ADMC decision was made.

The DMERCs *and DMERC PSCs* reserve the right to review claims on a pre- or post-payment basis and, notwithstanding the requirements of this section, may deny claims and take appropriate remedy if they determine that an affirmative ADMC decision was made based on incorrect information.

*5.*7.6 – Negative ADMC Decisions

(Rev. 71, 04-09-04)

A negative ADMC decision communicates to the supplier and the beneficiary that, based on the information submitted with the request, the beneficiary does not meet the medical necessity requirements Medicare has established for the item. The negative ADMC decision should indicate why the request was denied.

A beneficiary or a supplier can resubmit an ADMC request if additional medical documentation is obtained that could affect the prior negative ADMC decision. However, requests may only be submitted once during a 6-month period.

*5.*7.7 – DMERC *and DMERC PSC* Tracking

(Rev. 71, 04-09-04)

DMERCs *and DMERC PSCs* shall develop the capability to track ADMC requests in order to assure that decisions are rendered in a timely and appropriate fashion. DMERCs *and DMERC PSCs* shall also develop the capability to ensure that 1) items for which an affirmative ADMC decision was made are not denied as not meeting the medical necessary requirements of the policy, and 2) claims for item that received a negative ADMC decision are denied as not covered, unless additional medical documentation submitted with the claims supports coverage.

Medicare Program Integrity Manual

Chapter 6 - Intermediary MR Guidelines for Specific Services

Table of Contents

(Rev. 71, 04-09-04)

*6.*1 – Medical Review of Skilled Nursing Facility Prospective Payment System (SNFPPS) Bills

(Rev. 71, 04-09-04)

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 and various look back periods for the time that is covered by that MDS. Medicare expects to pay at the rate based on the most recent clinical assessment, i.e., MDS, until the next required assessment is due **or** until skilled care is no longer needed. 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 of medical review for SNFs has changed under the prospective payment system from a review of individualized services to a review of the beneficiary's clinical condition. Medical review decisions are based on the observation, look back periods relevant to the MDS(s), and supporting documentation for the claim period billed.

"Rules of thumb" in the MR process are prohibited. Intermediaries 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 FIs are to review, when indicated, Medicare SNF PPS bills, except for the excluded services identified in §4432(a) of the BBA and PM A-98-37. The goal of medical review is to determine whether the services are reasonable and necessary, delivered in the appropriate setting, delivered and coded correctly, and appropriately documented. Under PPS, beneficiaries must continue to meet the regular eligibility requirements for a SNF stay as described in MIM §3131 (e.g., 3-day medically necessary hospital stay, transfer to a participating SNF within 30 days after discharge from the hospital, and the services must be for treatment of a condition for which the beneficiary was treated in the hospital or one that arose while in the SNF for treatment of a condition for which he was treated in the qualifying hospital stay).

Under PPS the beneficiary must continue to 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 upper 26

RUG-III 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 assessment reference date 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 assessment reference date for the initial Medicare required 5-day assessment. For all days subsequent to the assessment reference date of the Medicare required 5-day assessment or for cases where the provider billed HIPPS codes indicating that the beneficiary was correctly assigned to one of the lower 18 RUG-III groups, you are to review the bill and supporting medical information to determine whether the beneficiary did indeed meet the SNF level of care requirement. If the beneficiary met the level of care requirement, you are to also determine whether the furnished services and intensity of those services, as defined by the billed RUG-III group, were reasonable and necessary for the beneficiary's condition payable according to the final rule. To determine if the beneficiary was correctly assigned to a RUG-III group, you are to verify that the billed RUG-III group is supported by the associated provider documentation. You are to 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.

*6.*1.1 - Types of Review

(Rev. 71, 04-09-04)

FI's should no longer perform random postpayment reviews specific to SNFPPS bills. Instead, SNFPPS MR should be conducted on a prepayment targeted basis. Where an FI cannot perform prepayment review for SNFPPS bills, targeted reviews may be conducted on a postpayment basis. Consider the principles of Progressive Corrective Action when conducting MR. (See Program Memorandum AB-00-72, "Medical Review—Progressive Corrective Action" dated August 7, 2000. FIs are also required to continue review of demand bills. (See B below.)

A – Targeted (Focused) Reviews

FIs are to conduct targeted reviews, focusing on specific program vulnerabilities inherent in the PPS as well as provider/service specific problems.

- Bill Selection--In selecting their overall workload, an FI may choose specific claims or target providers with high error rates, and must include newly participating providers.

  - In addition, CMS may be directing targeted reviews based on data obtained from the CMS Repository or other sources.

  - Continue to track and report edit effectiveness through the standard activity reports.

B - Demand Bills

Intermediaries 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 wishes the bill to be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. The SNF must have a written request from the beneficiary to submit the bill, 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.)

When determining eligibility for Medicare coverage, review to determine that both technical and clinical criteria are met. In the absence of a completed MDS, review the medical record and documentation, including the notice of noncoverage, to determine provider/beneficiary liability. If you disagree with the provider's decision of noncoverage, follow the medical review instructions in §*6.*1.3 to determine that the services were reasonable and necessary and use the RUG-III Adjustment Matrices (EXHIBIT II) to adjust the RUG-III code billed if necessary.

The HIPPS code and revenue code 0022 must be present on the demand bill. If an MDS has been completed, the provider must use the RUG-III group from that MDS, even if it is one of the top 26 RUG-III groups. If no assessment was completed, the provider may use the default code. If the 14-day State assessment has an assessment reference date 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 that Medicare-required assessment.

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 FI requests a copy of the notice.

*6.*1.2 - Bill Review Requirements

(Rev. 71, 04-09-04)

FIs must conduct review of SNF PPS bills in accordance with these instructions. This includes all applicable PIM sections, FI 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 III classification. The last two characters are numeric indicators of the reason for the MDS assessment. (See Exhibit III, SNF PPS Assessment Indicator Codes.)

*6.*1.3 - Bill Review Process

(Rev. 71, 04-09-04)

A - Request Records

FIs must request documentation necessary to make a MR determination. FIs are to use the MDS as part of the medical documentation used to determine whether the HIPPS codes billed were accurate and appropriate. As a result, when you solicit information necessary to support a medical review decision, include a request for a hardcopy version of each MDS related to the billing period being reviewed. An electronic copy that replicates the hardcopy version of the MDS is acceptable. You must also request documentation to support the HIPPS code(s) billed, including notes related to the assessment reference date, 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 assessment reference date for each MDS marks the end of the look back period (which may extend back 30 days), the FI must be sure to obtain supporting documentation for up to 30 days prior to the assessment reference date 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 support 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.

- You are to 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. We expect that review of the bill (i.e., UB-92) alone would not provide sufficient information in making a coverage determination.

    - During the review process, if the provider fails to furnish you with solicited documentation within the prescribed time frame, deny the bill and/or adjust the claim accordingly. 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. A denial based on §1862(a)(1)(A) of the Act is subject to appeal rights.

    - During the review of demand bills, continue current prepayment operating procedures 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 services provided were covered. In order to be covered, a service must meet all three of the following criteria:

- **Level of care requirement must be met**--Determine whether the services met the requirements according to the Final Rule, CMS-1913-F. The Final Rule reinstated management and evaluation of a care plan, observation and assessment of the patient's changing condition, patient education, and insertion and sterile irrigation and replacement of suprapubic catheters as examples of skilled care.

    - 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 upper 26 RUG-III groups, this creates a presumption of coverage. This meets the requirements of 42 CFR 409.31 for the period from the first day of the Medicare covered stay up to, and including, the assessment reference date for that assessment but not later than day 8 of the covered stay. This presumption does not arise in connection with any of the subsequent assessments, but applies specifically to the period ending with the assessment reference date for the initial Medicare required 5-day assessment. For all other assessments, determination of the continued need for, and receipt of, a skilled level of care will be based on the beneficiary's overall clinical status and needs for the dates of service under review. 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 during the review of medical records.

- The above criteria for determining the need for and receipt of a skilled level of care also applies to beneficiaries assigned to one of the lower 18 RUG-III groups.

- Management and evaluation of a patient care plan refers to the management and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel. Skilled management would be required where the sum total of unskilled services which are a necessary part of the medical regimen, when considered in light of the patient's overall condition, makes the involvement of skilled nursing personnel necessary to promote the patient's recovery and medical safety.

- Observation and assessment of a patient's condition refers to skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized.

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode. "Reasonable probability" means that a potential complication or further acute episode was a likely possibility.

- **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 clinical condition and/or services indicated on the MDS are reasonable and necessary for the beneficiary's condition as reflected by medical record documentation. If you determine that some or all of the services were not reasonable and necessary at the RUG level billed, which if disallowed would result in reclassification to a lower RUG-III category (using the chart in EXHIBIT I--MDS2.0 RUG III Codes), adjust the bill according to the matrices in EXHIBIT II--RUG-III Adjustment

Matrices. For examples of case review determinations, see EXHIBIT III--Medical Review Outcomes.

It is important to recognize the possibility that the necessity of some services could be questioned and yet not impact the RUG-III classification. The RUG-III classification may not change because there are many clinical conditions and treatment regimens that qualify the beneficiary for the RUG-III 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 though the reviewer notices that the documentation of his fever does not support the presence of a fever during the assessment period under review. Although fever with tube feeding is a qualifier for classification into the Special Care category, so is tube feeding with aphasia. The beneficiary is still being tube fed and is still aphasic; that combination of clinical conditions is adequate to qualify him for the Special Care category. None of the qualifying conditions listed on the chart in Exhibit I of this document has a higher weight than any other, and the presence of any one condition or combination of conditions as listed is adequate for classification. If that occurs, no change in RUG-III classification should be made. If the medical record does not support one or both of the above conditions, appropriate adjustment to the RUG-III classification should be made.

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 (PIM Chapter *4*.)

C - Outcome of Review

After making a medical review determination, take appropriate actions using the following guidelines. (Also Refer to Exhibit IV for Specific Examples of Medical Review Outcomes.)

- HIPPS Codes Indicating Classification into a Rehabilitation Group

  - **Rehabilitation Services Reasonable and Necessary At Level Billed--** If the rehabilitation services were appropriate at the level billed during the time of the relevant assessment period for the timeframe being billed, accept the claim as billed for the entire payment period, even if the level of therapy changed during the payment period.

  - **Rehabilitation Services Reasonable and Necessary but Not at Billed Level--**If the rehabilitation services were appropriate, but not at the level billed, during the time of the relevant assessment period for the timeframe being billed, adjust the billed RUG-III code according to Matrix A of RUG-III Adjustment Matrices, EXHIBIT II for the entire payment period.

- **Rehabilitation Services 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, use EXHIBIT I to determine if there is a clinical group for which the beneficiary qualified. Based on the selected category, adjust the RUG-III code billed according to Matrix B of Rug-III Adjustment Matrices, EXHIBIT II for the entire payment period. If there are no other skilled services indicated in the medical records, deny all days.

- **Rehabilitation Services Projected On 5-Day Assessment Not Provided--**If rehabilitation services are not provided at the level projected on the 5-day assessment, look for documentation to support the reason the rehabilitation services were not provided. If documentation supports that the projection was made in good faith, e.g., the physician orders and the therapy plan of treatment reflect the projected level of minutes, accept the claim as billed.

    - If, however, the documentation does not support that rehabilitation services were reasonable and necessary at the projected level during the 5-day assessment period, adjust the RUG-III code billed according to Matrix A or B of Rug-III Adjustment Matrices, EXHIBIT II for the entire payment period.

- **All Rehabilitation Services Discontinued With No Other Medicare Required Assessment (OMRA)/Other Skilled Services Provided--**If the provider discontinued all rehabilitation services at some point during the payment period but did not complete an OMRA as required by Medicare 8-10 days after therapy is discontinued, pay at the HIPPS code billed for eight 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 Discontinued With No Other Medicare Required Assessment (OMRA)/No Other Skilled Services Provided--**If the provider discontinued all rehabilitation services at some point during the payment period but did not complete an Other Medicare Required Assessment (OMRA) as required by Medicare 8-10 days after therapy is discontinued) and no other skilled care is needed, deny the claim from the date that the rehabilitation services were discontinued.

- **All Rehabilitation Services Become Not Reasonable and Necessary--Skilled Need Continues--**If you determine that all provided rehabilitation services are no longer reasonable and necessary at some point during the payment period but that other skilled services are being provided, use EXHIBIT I to determine the clinical group for which the beneficiary

qualified. Based on the selected category, adjust the RUG-III code billed according to Matrix B of Rug-III Adjustment Matrices, EXHIBIT II from the date that the rehabilitation services are determined to be not reasonable and necessary.

- **All Rehabilitation Services Become Not Reasonable and Necessary--No Skilled Need Continues--**If you determine that provided rehabilitation services are no longer reasonable and necessary at some point during the payment period and that no other skilled services are being provided, deny the bill from the date that the rehabilitation services are determined to be not reasonable and necessary.

- HIPPS Codes Indicating Classification into a Clinical Group

  - **Services Reasonable and Necessary At Level Billed--**If services were appropriate at the level billed during the time of the relevant assessment period for the timeframe being billed, accept the claim as billed for the entire payment period, even if the level of skilled care changes during the payment period.

  - **Services Not Reasonable and Necessary At Level Billed--**If the clinical group billed was not appropriate during the time of the relevant assessment period for the timeframe being billed, select the proper category that reflects the skilled services provided to the beneficiary or the beneficiary's clinical condition at the time of the observation period (e.g., Extensive Services, Special Care, Clinically Complex) according to the MDS2.0 RUG III Codes chart (EXHIBIT I). Based on the selected category, adjust the billed RUG-III code according to Matrix B of RUG-III Adjustment Matrices, EXHIBIT II for the entire payment period.

  - **Need For Skilled Care Ends--**If you determine that the beneficiary falls to a non-skilled level of care at some point during the payment period, discontinue Medicare coverage effective when the beneficiary no longer meets level of care criteria.

- HIPPS Codes Indicating Classification into the Lower 18 RUG-III Groups

  - **Lower 18 RUG-III Group Billed - Level of Care Criteria Met--**If the beneficiary met the SNF level of care criteria as defined in Section 6.1.3B, accept the claim as billed for the entire payment period, as long as skilled need remains.

  - **Lower 18 RUG-III Group Billed - Level of Care Criteria Not Met--**If the beneficiary did not meet the SNF level of care criteria as defined in Section 6.1.3B, deny the bill in full for the entire payment period.

- General Information For All HIPPS Codes

  - **No Skilled Care Needed or Provided--**If you determine that none of the services furnished were reasonable and necessary and that no skilled care is needed or provided, deny the bill from the date that care was determined to be non-covered.

  - **Services Billed But Not Furnished--**If you determine that any of the services billed were not furnished, deny the bill in part or full for the entire payment period and, if applicable, apply the fraud and abuse guidelines in PIM Chapter *4*.

A partial denial is defined as either the disallowance of specific days within the stay or reclassification into a lower RUG-III 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-III 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.

*6.*1.4 - Workload

(Rev. 71, 04-09-04)

All FIs 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.

*6.*1.5 - Data Analysis

(Rev. 71, 04-09-04)

Conduct data analysis to identify normal practice patterns, aberrancies, potential areas of overutilization, and patterns of noncovered care. This MR activity should add a strong foundation for targeting medical review of claims. As indicated in PIM Chapter 2, continue data collection and analysis of SNF PPS billing information, data from other Federal sources (QIOs, carriers, 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 bills where there is the greatest risk of inappropriate program payment.

*6.*1.6 - MIP-PET

(Rev. 71, 04-09-04)

Education is key to ensure proper billing. As problems are identified, FIs should not only educate the individual providers of problems, but also the SNF community about the results of their review and of common problems found through medical review. This education should be as interactive as possible. FIs should be proactive in using the results of medical review to educate providers and prevent future errors. The costs associated with these work products and activities are to be budgeted and charged to the appropriate MIP-PET CAFM2 code.

*6.*1.*7* – Reporting

(Rev. 71, 04-09-04)

Reporting requirements will be issued under separate instructions.

EXHIBIT I

MDS2.0 RUG III Codes

CATEGORY	ADL INDEX	END SPLITS	MDS RUG III CODES
REHABILITATION			
ULTRA HIGH Rx 720 minutes a week minimum At least 2 disciplines, 1st -5 days, 2nd - at least 3 days	16-18 9-15 4-8	NOT USED NOT USED NOT USED	RUC RUB RUA
VERY HIGH Rx 500 minutes a week minimum At least 1 discipline - 5 days	16-18 9-15 4-8	NOT USED NOT USED NOT USED	RVC RVB RVA
HIGH Rx 325 minutes a week minimum 1 discipline 5 days a week	13-18 8-12 4-7	NOT USED NOT USED NOT USED	RHC RHB RHA

MEDIUM Rx 150 minutes a week minimum 5 days across 1, 2 or 3 disciplines	15-18 8-14 4-7	NOT USED NOT USED NOT USED	RMC RMB RMA
LOW Nrsg. Rehab 6 days in at least 2 activities and Rehabilitation therapy Rx 3 days/ 45 minutes a week minimum	14-18 4-13	NOT USED NOT USED	RLB RLA
EXTENSIVE SERVICES - (if ADL <7, beneficiary classifies to Special Care) IV feeding in the past 7 days (K5a) IV medications in the past 14 days (P1ac) Suctioning in the past 14 days (P1ai) Tracheostomy care in the last 14 days (P1aj) Ventilator/respirator in the last 14 days (P1al)	7-18 7-18 7-18	new grouping: count of other categories code into plus IV Meds + Feed	SE3 SE2 SE1
SPECIAL CARE -- (if ADL <7 beneficiary classifies to Clinically Complex) Multiple Sclerosis (I1w) and an ADL score of 10 or higher Quadriplegia (Ilz) and an ADL score of 10 or higher Cerebral Palsy (Ils) and an ADL score of 10 or higher Respiratory therapy (P1bdA must = 7 days) Ulcers, pressure or stasis; 2 or more of any stage (M1a,b,c,d) and treatment (M5a, b,c,d,e,g,h) Ulcers, pressure; any stage 3 or 4 (M2a) and treatment (M5a,b,c,d,e,g,h) Radiation therapy (P1ah) Surgical, Wounds (M4g) and treatment (M5f,g,h) Open Lesions (M4c) and treatment (M5f,g,h) Tube Fed (K5b) and Aphasia (I1r) and feeding accounts for at least 51 percent of daily calories (K6a=3 or4) OR at least 26 percent of daily calories and 501cc daily intake (K6b=2,3,4 or 5) Fever (J1h) with Dehydration (J1c),	17-18 15-16 7-14	NOT USED NOT USED NOT USED	SSC SSB SSA

Pneumonia (Ie2),Vomiting (J1o) or Weight loss (K 3a) Fever (J1h) with Tube Feeding (K5b) and, as above, (K6a=3 or 4) &/or (K6b = 2,3,4,or 5)			
CLINICALLY COMPLEX -- Burns (M4b) Coma (B1) and Not awake (N1 = d) and completely ADL dependent (G1aa, G1ba, G1ha, G1ia = 4 or 8) Septicemia (I2g) Pneumonia (I2e) Foot / Wounds (M6b,c) and treatment (M6f) Internal Bleed (J1j) Dialysis (P1ab) Tube Fed (K5b) and feeding accounts for: at least 51% of daily calories (K6a = 3 or 4) OR 26 percent of daily calories and 501cc daily intake (K6b = 2, 3, 4 or 5) Dehydration (J1c) Oxygen therapy (P1ag) Transfusions (P1ak) Hemiplegia (I1v) and an ADL score or 10 or higher Chemotherapy (P1aa) No. Of Days in last 14 there were Physician Visits and order changes: visits >=1 days and order changes >=4 days; or visits >=2 days and order changes on >=2 days Diabetes mellitus (I1a) and injections on 7 days (O3 >= 7) and order changes >=2 days (P8 >= 2)	17-18D 17-18 12-16D 12-16 4-11D 4-11	Signs of Depression Signs of Depression Signs of Depression	CC2 CC1 CB2 CB1 CA2 CA1
IMPAIRED COGNITION Score on MDS2.0 Cognitive Performance Scale >= 3	6-10 6-10 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving	IB2 IB1 IA2 IA1
BEHAVIOR ONLY Coded on MDS 2.0 items: 4+ days a week - wandering, physical or verbal abuse.	6-10 6-10 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving	BB2 BB1 BA2 BA1

inappropriate behavior or resists care; or hallucinations, or delusions checked			
PHYSICAL FUNCTION REDUCED No clinical conditions used	16-18 16-18 11-15 11-15 9-10 9-10 6-8 6-8 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving	PE2 PE1 PD2 PD1 PC2 PC1 PB2 PB1 PA2 PA1
			Default

*To qualify as receiving Nursing Rehabilitation, the rehabilitation must be in at least 2 activities, at least 6 days a week. As defined in the Long Term Care RAI User's Manual, Version 2 activities include: Passive or Active ROM, amputation care, splint or brace assistance and care, training in dressing or grooming, eating or swallowing, transfer, bed mobility or walking, communication, scheduled toileting program or bladder retraining

EXHIBIT II

RUG-III ADJUSTMENT MATRICES

Matrix A

RUG Category Billed	Adjust to:
Rehabilitation - RUC, RVC, RHC	RMC
Rehabilitation - RUB, RVB, RHB	RMB
Rehabilitation - RUA, RVA, RHA	RMA
Rehabilitation - RMC	RLB
Rehabilitation -RMB, RMA	RLA

Note: The adjusted RUG codes in the above matrix, were determined by selecting the RUG code in the Medium rehabilitation service category that most closely matched the billed ADLs. Services billed in the Medium Rehabilitation category were reduced to Low Rehabilitation category.

MATRIX B

RUG Category Billed	**Adjust to:**				
	Extensive Services	**Special Care**	**Clinically Complex**	**Lower 18**	**Not R&N and** no other RUG-III qualifying clinical condition
Rehabilitation - RUC, RVC, RHC, RMC, RLB	SE1	SSC	CC1	PA1	Deny
Rehabilitation - RUB, RVB, RHB, RMB	SE1	SSA	CB1	PA1	Deny
Rehabilitation - RUA, RVA, RHA, RMA, RLA	X	CA1	CA1	PA1	Deny
Extensive Services - SE3, SE2, SE1	X	SSA	CA1	PA1	Deny
Special Care – SSC	X	X	CC1	PA1	Deny
Special Care – SSB	X	X	CB1	PA1	Deny
Special Care – SSA	X	X	CA1	PA1	Deny
Clinically Complex - CC2, CC1, CB2, CB1, CA2, CA1	X	X	X	PA1	Deny
All Lower 18 RUG III Codes	X	X	X	PA1	Deny

NOTE: The adjusted RUG codes in the above matrix were determined by selecting the RUG code for each category that most closely matched the ADL index of the billed RUG code. When the ADL index was the same for the entire category the lowest RUG code in that category was selected. In some cases, the adjusted RUG code may fall into a different category than was selected when using the MDS2.0 RUG III Codes chart (EXHIBIT I) because of a low ADL index.

When using Matrix B to reclassify a case for payment, there will be instances in which the reviewer will need to calculate the ADL score in order to determine for which RUG-III group the beneficiary qualifies. For example, if a bill at a rehabilitation RUG-III group level comes in for review and the reviewer determines that none of the rehabilitation therapy service that was provided was reasonable and necessary, the bill will be re-classified using Matrix B. The process for this re-classification relies on the reviewer being able to determine for which of the clinical RUG-III groups the beneficiary qualifies.

There are four instances in which the combination of a diagnosis and an ADL score are the qualifying condition for the RUG-III category. These four combinations are: Quadriplegia with an ADL score of 10 or higher, Multiple Sclerosis with an ADL score of 10 or higher, Cerebral Palsy with an ADL score of 10 or higher and Hemiplegia with an ADL score of 10 or higher. The first three combinations qualify the beneficiary for the Special Care category, the last combination is a qualifier for the Clinically Complex category.

Although it is not appropriate to alter the ADL values reported on the MDS, the reviewer can use those values to calculate the ADL score that is used for RUG-III classification. The following exhibit illustrates how to perform this calculation. Notice that not all of the ADL items in section G of the MDS are relevant for the calculation of the RUG-III ADL sum score. Use only the items used in the explanation below (G1a, G1b, G1h, G1i). Additionally, items K5a, K5b, K6a and K6b are used in the calculation for beneficiaries who receive a significant portion of their nutrition enterally or parenterally.

To calculate the RUG-III ADL Sum Score:

First, calculate the RUG-III ADL scores for items G1a, G1b and G1i.

MDS ITEM	IF COLUMN A VALUE=	IF COLUMN B VALUE=	ADL SCORE=	SCORE
G1a	0 or 1	any number	1	
	2	any number	3	
	3, 4 or 8	<=2	4	
	3, 4 or 8	3 or 8	5	G1a=
G1b	Calculate this score using the same values as for G1a			G1b=
G1I	Calculate this score using the same values as for G1a			G1i=

Next, check the items related to enteral and parenteral feeding. If item **K5a** is checked, and item **K6a** indicates that the beneficiary received at least 51 percent of his calories parenterally, **or** if items **K6a and K6b** together indicate that the beneficiary received at least 26 percent of his calories and at least 501 cc fluids per day parenterally, then the eating ADL score is 3.

If **K5b** is checked, and item **K6a** indicates that the beneficiary received at least 51 percent of his calories via tube feedings **or** items **K6a and K6b** together indicate that the

beneficiary received at least 26 percent of his calories and at least 501 cc of fluid via tube feedings, then the ADL score for eating is 3.

If either **K5a or K5b** is checked and **K6a** and **K6b** do not have values that indicate that the minimum amounts of fluid and/or calories were received by the beneficiary, then there is no ADL score for enteral/parenteral feeding to be added.

If beneficiary does not receive a score of 3 based on K5a, K5b, K6a and K6b, then go on to items G1h (eating).

MDS ITEM	If COLUMN A VALUE=	ADL SCORE =	SCORE
G1h	0 or 1	1	
	2	2	
	3, 4 or 8	3	G1h=

Sum the values for G1a, G1b, G1i. Add 3, if appropriate, based on the enteral/parenteral values or, if the beneficiary is not being tube or parenterally fed at a level high enough to warrant the score of 3, add the value from the calculation for G1h instead. The final sum is the ADL score used by the grouper to classify beneficiaries into the RUG-III groups.

EXAMPLE: A beneficiary's MDS reports the following scores in the relevant items of section G of the MDS 2.0:

MDS ITEM	**A**	**B**	**ADL Score**
G1a	1	2	1
G1b	1	1	1
G1h	1	1	1
G1i	2	2	3

This beneficiary's score is a 6. (1+1+1+3=6)

EXHIBIT III

SNFPPS
ASSESSMENT INDICATOR CODES

MODIFIER	TYPE OF ASSESSMENT
01	5-day Medicare-required assessment/not an initial admission assessment
02	30-day Medicare-required assessment
03	60-day Medicare-required assessment
04	90-day Medicare-required assessment
05	Readmission/Return Medicare-required assessment
07	14-day Medicare-required assessment/not an initial admission assessment
08	Off-cycle Other Medicare-required assessment (OMRA)
11	5-day (or readmission/return) Medicare-required assessment AND initial admission assessment
17	14-day Medicare-required assessment and initial admission assessment: This code is being activated to facilitate the planned automated generation of all assessment indicator codes. Currently, code 07 is used for all 14-day Medicare assessments, regardless of whether it is also a clinical initial admission assessment (i.e., an assessment mandated a part of the Medicare/Medicaid certification process).
18	OMRA replacing 5-day Medicare-required assessment
28	OMRA replacing 30-day Medicare-required assessment
30	Off-cycle significant change assessment (outside assessment window)
31	Significant change assessment REPLACES 5-day Medicare-required assessment
32	Significant change assessment REPLACES 30-day Medicare-required assessment
33	Significant change assessment REPLACES 60-day Medicare-required assessment
34	Significant change assessment REPLACES 90-day Medicare-required assessment
35	Significant change assessment REPLACES a readmission/return Medicare-required assessment
37	Significant change assessment REPLACES 14-day Medicare-required assessment
38	OMRA replacing 60-day Medicare-required assessment

40	Off-cycle significant correction assessment of a prior assessment (outside assessment window)
41	Significant correction of a prior assessment REPLACES 5-day Medicare-Required assessment
42	Significant correction of a prior assessment REPLACES 30-day Medicare-Required assessment
43	Significant correction of a prior assessment REPLACES 60-day Medicare-Required assessment
44	Significant correction of a prior assessment REPLACES 90-day Medicare-Required assessment
45	Significant correction of a prior assessment REPLACES a readmission/return assessment
47	Significant correction of a prior assessment REPLACES 14-day Medicare-Required assessment
48	OMRA replacing 90-day Medicare-required assessment
54	90-day Medicare assessment that is also a quarterly assessment
78	OMRA replacing 14-day Medicare-required assessment
00	Default code

EXHIBIT IV

EXAMPLES OF MEDICAL REVIEW OUTCOMES

HIPPS Codes Indicating Classification into a Rehabilitation Group

1. **Rehabilitation Services Reasonable and Necessary At Level Billed--**If the rehabilitation services were appropriate at the level billed during the time of the relevant assessment period for the timeframe being billed, accept the claim as billed for the entire payment period, even if the level of therapy changed during the payment period.

Services Billed: **RHC07 for days 15-30**

Supporting Documentation:

MDS:

- 14 day assessment

- P1ba indicated speech therapy 5days/150 minutes
- P1bb indicated occupational therapy 5 days/150 minutes
- P1bc indicated physical therapy 5 days/150 minutes

Medical Record:

- The resident was hospitalized for 8 days for an acute CVA.
- In the 7-day look-back period including the assessment reference date (ARD) he received 450 minutes of therapy.
- The therapy documentation shows that ST, OT & PT are each treating him/her for 30 minutes each day.
- The evaluation and progress notes indicate the patient has deficits in speech, swallowing, activities of daily living (ADLs), range of motion (ROM) and mobility.
- OT is discontinued on the 20th day because the beneficiary's condition had improved.

Review Determination:

- The claim would be paid as billed for the entire payment period even though the level of therapy decreased during the payment period.

HIPPS Codes Indicating Classification into a Rehabilitation Group

2. **Rehabilitation Services Reasonable and Necessary but Not at Billed Level--**If the rehabilitation services were appropriate, but not at the level billed, during the time of the relevant assessment period for the timeframe being billed, adjust the billed RUG-III code according to Matrix A of RUG-III Adjustment Matrices, EXHIBIT II for the entire payment period.

Services Billed: RUC07 for days 15-30

Supporting Documentation

MDS:

- 14 day assessment
- P1ba indicated speech therapy 5 days/240 minutes
- P1bb indicated occupational therapy 5 days/240 minutes
- P1bc indicated physical therapy 5 days/240 minutes

Medical Record:

- The resident was hospitalized for 8 days with a diagnosis of acute CVA.

- Speech Therapy notes indicated that therapy services were provided BID on 5 days/240 minutes during the look back period.
- Occupational Therapy notes indicated that therapy services were provided BID on 5 days/240 minutes during the look back period.
- Physical Therapy notes indicated that therapy services were provided BID on 5 days/240 minutes.
- Documentation in the nursing notes indicated that the patient complained of being exhausted at the end of the day and requested that BID therapy be discontinued.
- Therapy progress notes indicated that the patient participated minimally in his afternoon therapy sessions due to complaints of fatigue.

Review Determination:

- The documentation supports the medical necessity of rehabilitative services but not at the level billed.
- The documentation indicated that the therapy provided with every day (QD) services by all therapy disciplines met/exceeded the requirements for the rehab medium category.
- Using Matrix A, the claim would be down-coded to RMC07.

HIPPS Codes Indicating Classification into a Rehabilitation Group

3. **Rehabilitation Services 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, use EXHIBIT I to determine if there is a clinical group for which the beneficiary qualified. Based on the selected category, adjust the RUG-III code billed according to Matrix B of Rug-III Adjustment Matrices, EXHIBIT II for the entire payment period.

SCENARIO 3a:

Services Billed: **RHB07 for days 15-30**

Supporting Documentation:

MDS:

- 14 day assessment
- P1ba indicated speech therapy was provided 5 days/325 minutes

Medical Record:

- The resident was hospitalized as an acute care patient for an exacerbation of Chronic Obstructive Pulmonary Disease (COPD) for greater than 3 days.
- Upon admission to the SNF, Speech Therapy began treating the resident for a "speech impediment." Nursing notes, social services notes, and dietary notes indicated that the patient's speech was clear and coherent and he was able to make his needs known. The documentation did not establish the medical necessity for skilled Speech Therapy intervention, a skilled need for a condition which was treated during the resident's qualifying hospital stay, or skilled intervention for a condition which arose while in the facility as a result of a condition treated during the qualifying hospital stay.

Review Determination 3a: No other skilled needs documented

- The HIPPS code billed would be denied because the services were not reasonable and necessary.

SCENARIO 3b:

Services Billed: RHB07 for days 15-30

Supporting Documentation:

MDS:

- 14 day assessment
- P1ba indicated speech therapy 5 days/325 minutes
- P1ac indicated IV medications in the last 14 days
- The patient's ADL Sum Score totaled 10

Medical Record:

- The resident was hospitalized as an acute care patient for an exacerbation of Chronic Obstructive Pulmonary Disease (COPD) with pneumonia for greater than 3 days.
- Upon admission to the SNF, Speech Therapy began treating the resident for a "speech impediment." Nursing notes, social services notes, and dietary notes indicated that the patient's speech was clear and coherent and he was able to make his needs known. The documentation did not establish the medical necessity for skilled Speech Therapy intervention.
- The documentation in the Medication Administration Record (MAR) indicated the patient received IV antibiotics in the 14-day look-back period including the ARD for pneumonia.

Review Determination 3b: Another skilled need was identified

- The documentation does not support the level billed.

- The HIPPS code billed would be down-coded to SE107 using Matrix B.

HIPPS Codes Indicating Classification into a Rehabilitation Group

4. **Rehabilitation Services Projected On 5-Day Assessment Not Provided**
   If rehabilitation services are not provided at the level projected on the 5-day assessment, look for documentation to support the reason the rehabilitation services were not provided. If documentation supports that the projection was made in good faith, e.g., the physician orders and the therapy plan of treatment reflect the projected level of minutes, accept the claim as billed.

SCENARIO 4a:

Services Billed: RHC01 for days 1-14

Supporting Documentation:

MDS:

- 5 day assessment
- T1c indicated the projected therapies would total 10 days
- T1d indicated the projected therapies would total 900 minutes

Medical Record:

- The actual therapy minutes for this assessment were 5 days/450 minutes.
- ST, OT & PT each documented 30 minutes of treatment per day for 5 days.
- Dr orders and plan of treatment were for all three therapies at 5 days each week.
- During the 2nd week of treatment the resident was ill with nausea, vomiting and diarrhea and was unable to participate in therapies for 2 days.

Review Determination 4a: The medical necessity of the therapy service is demonstrated at the level billed.

- The illness was unforeseen. The documentation showed that the projection was made in good faith. The HIPPS code billed would be paid.

SCENARIO 4b:

Services Billed: RHC01 for days 1-14

Supporting Documentation:

MDS:

- 5 day assessment
- T1c indicated the projected therapies would total 10 days
- T1d indicated the projected therapies would total 900 minutes

Medical Record:

- Dr orders and plan of treatment were for all three therapies at 5 days each week.
- There was no documentation to support therapy services being rendered and no rationale as to why they were not provided.

Review Determination 4b: Documentation did not show therapy minutes were provided.

- The HIPPS code billed would be denied for the entire payment period because the services provided were not reasonable and medically necessary.
- Quality of Care concerns should be referred to the RO *(for PSCs, the GTL, Co-GTL, and SME)* for referral to the State Agengy.

SCENARIO 4c:

Services Billed: RHC01 for days 1-14

Supporting Documentation:

MDS:

- 5 day assessment
- T1c indicated the projected therapies would total 10 days
- T1d indicated the projected therapies would total 900 minutes

Medical Record:

- The patient's qualifying hospital stay diagnosis was aspiration pneumonia secondary to dysphagia/dysphasia.
- Documentation in the nursing notes indicated that the patient continued to cough with all fluid intake.
- The patient remained at his prior level of function as prior to his hospitalization.
- The actual therapy minutes documented in the therapist's progress notes for this assessment were 5 days and 450 minutes.
- ST, OT, and PT each documented 30 minutes each for 5 days totaling 450 minutes.

Review Determination 4c: The medical necessity of the therapy service at the level billed was not demonstrated in the documentation provided during the 5-day assessment period.

- Documentation does not support level billed.
- OT and PT were not medically reasonable or necessary to treat this patient's condition.
- ST was medically reasonable and necessary to treat this patient's condition for 30 minutes a day for 5 days per week
- The projection in T1c and T1d would be readjusted to 10days/300 minutes.
- Adjust the RUG-III code billed according to Matrix A of the Rug-III Adjustment Matrices, EXHIBIT II to pay at RMC for the entire payment period.

HIPPS Codes Indicating Classification into a Rehabilitation Group

5. **All Rehabilitation Services Discontinued With No Other Medicare Required Assessment (OMRA)/Other Skilled Services Provided** --If the provider discontinued all rehabilitation services at some point during the payment period but did not complete an OMRA as required by Medicare 8-10 days after therapy is discontinued, pay at the HIPPS code billed for eight 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.

Services Billed: RHC02 for days 31-60

Supporting Documentation:

MDS:

- 30 day MDS
- M1d indicated 1 Stage IV ulcer
- M5a,b,c,e,g,h were all checked
- P1bb indicated occupational therapy was provided 5 days/175 minutes
- P1bc indicated physical therapy was provided 5 days/175 minutes

Medical Record:

- The patient's qualifying hospital stay resulted from a fractured hip with repair.
- Therapies were found to be discontinued on day 40.

- The resident continued to be treated by nursing for a Stage IV. Decubitus Ulcer with twice a day (BID) medication and dressing, changes which resulted from the immobility caused by the fracture.

Review Determination

- No OMRA was completed by the facility.
- RHC02 would be paid through the 48th day (8 days after therapies discontinued – the first possible day an OMRA could/should have been completed).
- Days 49-60 would be down coded to AAA00 (the default rate), because the documentation does not support level billed.

HIPPS Codes Indicating Classification into a Rehabilitation Group

6. **All Rehabilitation Services Discontinued With No Other Medicare Required Assessment (OMRA)/No Other Skilled Services Provided—**If the provider discontinued all rehabilitation services at some point during the payment period but did not complete an Other Medicare Required Assessment (OMRA) as required by Medicare 8-10 days after therapy is discontinued) and no other skilled care is needed, deny the claim from the date that the rehabilitation services were discontinued.

Services Billed: RHC02 for days 31-60

Supporting Documentation:

MDS:

- 30 day assessment
- P1bb indicated occupational therapy provided services 5 days/175 minutes
- P1bc indicated physical therapy services 5 days/175 minutes

Medical Record:

- The patient's qualifying hospital stay was for a fractured hip.
- Therapies were discontinued on day 40.
- There are no other skilled needs documented.

Review Determination:

- RHC02 would be paid for days 31-40.
- Days 41-60 would be denied because no skilled services were provided and services not reasonable andnecessary.

HIPPS Codes Indicating Classification into a Rehabilitation Group

7. **All Rehabilitation Services Become Not Reasonable and Necessary – Skilled Need Continues--**If you determine that all provided rehabilitation services are no longer reasonable and necessary at some point during the payment period but that other skilled services are being provided, use EXHIBIT I to determine the clinical group for which the beneficiary qualified. Based on the selected category, adjust the RUG-III code billed according to Matrix B of Rug-III Adjustment Matrices, EXHIBIT II from the date that the rehabilitation services are determined to be not reasonable and necessary.

Services Billed: RHC02 for days 31-60

Supporting Documentation:

MDS:

- 30 day assessment
- P1a indicated the patient received chemotherapy services during the last 14 days
- P1ba indicated the patient received speech therapy services 5 days/100 minutes
- P1bb indicated the patient received occupational therapy services 5 days/175 minutes
- P1bc indicated the patient received physical therapy services 5 days/175 minutes

Medical Record:

- The patient's acute care stay was for a Transient Ischemic Attack (TIA) and was diagnosed with Leukemia.
- On the 45th day, documentation shows the resident was independent with ADL's, ambulated independently with a rolling walker >300 feet with a steady gait, was able to feed himself without signs or symptoms (S/S) of swallowing difficulties, and speech was clear and coherent.
- The resident continued to receive chemotherapy at a local cancer center 5 days a week and was having nausea and vomiting.
- Documentation indicated that the patient's urine output was low and his skin turgor was poor.

Review Determination:

- Skilled rehab services were no longer R/N after day 45.
- The resident would qualify for the clinically complex category due to his chemotherapy and need for observation and assessment.

- The claim would be paid at RHC02 for days 31-45.
- Using Matrix B days 46-60 would be down-coded to CC102 because documentation does not support medical necessity at the level billed.

HIPPS Codes Indicating Classification into a Rehabilitation Group

8. **All Rehabilitation Services Become Not Reasonable and Necessary – No Skilled Need Continues--**If you determine that provided rehabilitation services are no longer reasonable and necessary at some point during the payment period and that no other skilled services are being provided, deny the bill from the date that the rehabilitation services are determined to be not reasonable and necessary.

Services Billed: RHC02 for days 31-60

Supporting Documentation:

MDS:

- 30 day assessment
- P1ba indicated speech therapy services 5 days/100 minutes
- P1bb indicated occupational therapy services 5 days/175 minutes
- P1bc indicated physical therapy services 5 days/175 minutes

Medical Record:

- The medical record indicated the patient's qualifying hospital stay diagnosis as TIA.
- On the 45th day, the documentation shows the resident was independent with ADL's, ambulated independently with a rolling walker >300 feet with a steady gait, was feeding himself without signs or symptoms (S/S) of swallowing difficulties, and his speech was clear and coherent.

Review Determination:

- There were no other documented skilled needs.
- Therapies were no longer R/N after day 45.
- The claim would be paid at RHC02 for days 31-45.
- Days 46-60 would be denied as skilled services were not medically reasonable or necessary.

HIPPS Codes Indicating Classification into a Clinical Group

9. **Services Reasonable and Necessary At Level Billed--**If services were appropriate at the level billed during the time of the relevant assessment period for the timeframe being billed, accept the claim as billed for the entire payment period, even if the level of skilled care changes during the payment period.

Services Billed: **SSB07 for days 15-30**

Supporting Documentation:

MDS:

- K5b Feeding Tube was checked
- K6a 4 (76-100%) was checked
- K6b 4 (1501- 2000cc's/day) was checked
- M4g surgical wound was checked
- M5f surgical wound care was checked

Medical Record:

- The patient was treated in his acute hospital stay for a surgically released bowel obstruction and malnutrition for which he had a PEG tube placed.
- Treatment to the surgical wound was clearly documented on the treatment sheets and in the nurse's notes for the 7-day look-back period including the ARD. The treatment was discontinued on day 20.
- The patient continued to be tube fed 100% of his caloric intake and > 1501 cc's daily.

Review Determination:

- The claim would be paid as billed for the entire payment period even though the level of skilled services decreased after day 20.

HIPPS Codes Indicating Classification into a Clinical Group

10. **Services Not Reasonable and Necessary At Level Billed--**If the clinical group billed was not appropriate during the time of the relevant assessment period for the timeframe being billed, select the proper category that reflects the skilled services provided to the beneficiary or the beneficiary's clinical condition at the time of the observation period (e.g., Extensive Services, Special Care, Clinically Complex) according to the MDS2.0 RUG III Codes chart (EXHIBIT I). Based on the selected category, adjust the billed RUG-III code according to Matrix B of RUG-III Adjustment Matrices, EXHIBIT II for the entire payment period.

Serviced Billed: SSB07 for days 15-30

Supporting Documentation:

MDS:

- 14 day assessment
- K5b Feeding tube checked
- K6a 4 (76-100%) checked
- K6b 4 (1501-2000cc/day) checked
- M5f surgical wound care checked

Medical Record:

- The patient was in the acute stay for an appendectomy and malnutrition for which she had a PEG tube placed.
- There was no surgical wound treatment documented in the look back period of this assessment.
- The patient continued to be tube fed 100% of her caloric intake & >1501cc's daily.

Review Determination:

- Using Matrix B days 15-30 would be down coded to CB107 because documentation does not support level billed.

HIPPS Codes Indicating Classification into a Clinical Group

11. **Need For Skilled Care Ends--**If you determine that the beneficiary falls to a non-skilled level of care at some point during the payment period, discontinue Medicare coverage effective when the beneficiary no longer meets level of care criteria.

Services Billed: SSB07 for days 15-30

Supporting Documentation:

MDS:

- 14 day assessment
- M4g Surgical wound checked
- M5f surgical wound care checked

Medical Record:

- The patient was in the acute hospital for the removal of a large tumor.

- Surgical wound care was clearly documented through day 20 when the treatment was discontinued and the wound was documented as healed.
- There were no other documented skilled needs from day 21 through day 30.

Review Determination:

- This claim would be paid at SSB07 for days 15-20.
- Days 21 through 30 would be denied because skilled services were no longer reasonable and necessary.
- The provider would be liable for days 21 through 30.

HIPPS Codes Indicating Classification into the Lower 18 RUG-III Group

12. **Lower 18 RUG-III Group Billed - Level of Care Criteria Met--**If the beneficiary met the SNF level of care criteria, accept the claim as billed for the entire payment period, as long as skilled need remains.

Services Billed: BB201 for days 1-7

Supporting Documentation:

MDS:

- 5 day assessment
- E4a Wandering + 3 (occurred daily) checked
- E4c Physically abusive behavioral symptoms = 3 (occurred daily) checked
- E4e Resists care = 3 (occurred daily) checked

Medical Record:

- The resident was in the acute care setting for greater than 3 days for a new onset of confusion and anxiety.
- Documentation clearly shows these behaviors on a daily basis in the seven-day look back period including the ARD and the behavior continued throughout the billing period.
- Documentation noted the need to switch the patient's medications being used to modify his behavior due to the sudden appearance of a rash over his entire body on the 4th day of his admission to the SNF.

Review Determination:

- This claim would be paid as billed.

HIPPS Codes Indicating Classification into the Lower 18 RUG-III Group

13. **Lower 18 RUG-III Group Billed--Level of Care Criteria Not Met**--If the beneficiary did not met the SNF level of care criteria, deny the bill in full for the entire payment period.

Services Billed: BB201 for days 1-7

Supporting Documentation:

MDS:

- 5 day assessment
- E4a Wandering + 3 (occurred daily) checked
- E4c Physically abusive behavioral symptoms = 3 (occurred daily) checked
- E4c Resists care = 3 (occurred daily) checked

Medical Record:

- The resident was in the acute care setting for greater than 3 days for a new onset of confusion and anxiety.
- The documentation provided did not show than any of these behaviors were exhibited.
- Nursing notes describe the patient as "pleasantly confused-easily reoriented."

Review Determination:

- The HIPPS code billed would be denied for the entire payment period because the services provided were not medically reasonable and necessary.

*6.*2- Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home"

(Rev. 71, 04-09-04)

A. General Information--RHHIs are instructed to do the following when a favorable final appellate decision that a beneficiary is "confined to home" is rendered on or after July 1, 2000.

NOTE: For the purposes of this manual section a favorable decision is a decision that is favorable to the beneficiary. A final appellate decision is a decision at any level of the appeals process where the RO *(for PSCs, the GTL, Co-GTL, and SME)*

has finally determined that no further appeals will be taken, or where no appeal has been taken and all time for taking an appeal has lapsed.

- Promptly pay the claim that was the subject of the favorable final appellate decision.
- Promptly pay or review based on the review criteria below:
- All claims that have been denied that are properly pending in any stage of the appeals process.
- All claims that have been denied where the time to appeal has not lapsed.
- All future claims submitted for this beneficiary.
- For favorable final appellate decisions issued during a one-year grace period starting on July 1, 2000, and ending June 30, 2001, reopen all denied claims that are subject to the 12-month reopening provision. Promptly pay or review, based on the review criteria below, these reopened claims.
- Establish procedures to ensure that medical review of a beneficiary's claim, after the receipt by that beneficiary of a favorable final appellate decision related to "confined to home," is reviewed based on the review criteria below.
- Notify the beneficiary and the affected home health agency that the favorable final appellate decision related to "confined to home" will be given "great weight" in evaluating if the beneficiary is "confined to home." Inform them of what steps should be taken if they believe a claim has been denied in error.
- Maintain records containing information on the beneficiaries receiving favorable final appellate decision related to "confined to home." These records should include at a minimum the beneficiary's name, HCIN number, service date of the claim that received the favorable final appellate decision and the date of this decision. This information should be made available to CMS upon request.

B. Review Criteria--Afford the favorable final appellate decision that a beneficiary is "confined to home" great weight in evaluating whether the beneficiary is confined to the home when reviewing services rendered after the service date of the claim addressed in the favorable final appellate decision unless there has been a change in facts (such as medical improvement or an advance in medical technology) that has improved the beneficiary's ability to leave the home. All medical review that is done on claims for services performed after the service date of the claim that is addressed in the favorable final appellate decision should determine if (a) there has been a change in facts (as noted above) that affects the beneficiary's ability to leave the home and (b) if the services provided meet all other criteria for home health care. If there have been no changes in facts that affect the beneficiary's ability to leave the home and if all other criteria for home health services are met, the claim would ordinarily be paid. Medical review staff should generally adhere to the following examples, if applicable, in effectuating this review.

EXAMPLE 1

A quadriplegic beneficiary receives a favorable final appellate decision that he is confined to the home even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight" in future medical review determinations, with the result that the beneficiary would therefore be treated as "confined to the home" in those determinations.

EXAMPLE 2

A diabetic beneficiary with a severely broken leg that is not healing well receives a favorable final appellate decision that he is confined to the home, even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight," with the result that the beneficiary would therefore be treated as "confined to the home" for subsequent medical review decisions. However, if upon review, evidence showed that the beneficiary's medical condition had changed and the ability to leave the home had improved then the favorable final appellate decision would no longer be given "great weight" in determining if the patient was "confined to home." Medical review of these cases should be done periodically to determine if there are changes in facts that have improved the beneficiary's ability to leave the home.