PROGRAM MEMORANDUM INTERMEDIARIES

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. A-00-08 **Date MARCH 2000**

CHANGE REQUEST 1064

SUBJECT: Payment Safeguard Review of Skilled Nursing Facility Prospective Payment Bills--Updated Instructions

The purpose of this Program Memorandum (PM) is to provide instructions for conducting medical review of skilled nursing facility (SNF) prospective payment system (PPS) claims according to the Final Rule (FR), HCFA-1913-F, published in the Federal Register dated July 30, 1999. This PM revises the medical review instructions issued in PM A-99-20, May 1999, to reflect changes in the coverage criteria made in the FR (see section B. Medical Review, and B.3.b. Make a Coverage Determination). We have also revised the medical review workload requirement for FY 2000 (see section D. Workload), added a new Medicare Summary Notice message (see section C. New Medicare Summary Notice Message), and supplemented the existing RUG-III Adjustment Matrices with an ADL score calculation chart (see EXHIBIT II). This PM is effective for bills with dates of service on or after October 1, 1999. For SNF PPS claims with dates of service before October 1, 1999, review in accordance with PM A-99-20.

Section 4432 of the Balanced Budget Act (BBA) of 1997 modified how Medicare payments are made for SNFs. Effective with cost reporting periods beginning on or after July 1, 1998, Medicare began paying SNFs on the basis of a prospective payment system. Section 1816 of the Social Security Act (the Act) requires fiscal intermediaries (FIs) to conduct audits of providers' records as needed to ensure that payments are proper. It is under this authority that the following medical review instructions will be implemented.

A. General--Effective with cost reporting periods beginning on or after July 1, 1998, Medicare began paying SNFs under a 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 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.

B. Medical Review (MR)--All FIs are to review 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 during the qualifying hospital stay).

Under PPS the beneficiary must continue to meet level of care requirements as defined in 42 CFR 409.31. HCFA 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.

1. Types of Review--Initially, the primary medical review strategy for SNF PPS bills is a manual, randomly selected, postpayment review process. FIs are also required to continue review of demand bills and to perform focused medical review. Continue the predominantly random claims selection until HCFA notifies you that medical review efforts should be more focused in nature.

a. Random Postpay --FIs are to perform a random postpayment review of bills. This review is a manual process and the determination of medical necessity should be performed only by a licensed or certified health professional.

The purpose of the random review is to get a cross-sectional overview of trends in beneficiary care and utilization of services under PPS. The information gained will support the FI's data analysis and aid in developing focused medical review criteria that will be unique to their particular provider population.

- Random Review Bill Selection--FIs are not expected to invest in extensive and costly systems changes, new sophisticated sampling processes, or complex techniques to select the sample. While FIs are not precluded from doing so, it is not expected that the sample support projection to a universe with any statistical confidence. However, you must adhere to the following guidelines.

-- FIs must randomly select for postpayment review the number of bills that they believe to be sufficient to ensure that providers are reporting correct information on the MDS and billing for covered SNF PPS services. The total number of randomly sampled bills must represent at least 80% of the budgeted SNF PPS workload level (see section D). The remaining 20% of the workload can be focused medical review (see b. below).

-- Your selection process must ensure that claims from all transitioned providers are "at risk" of being selected for review.

-- Currently there are 44 RUG codes that drive SNF PPS payment (EXHIBIT I). You are to consider all 44 RUG code categories (i.e., RUC through PA1) in the random review of postpayment bills. Also, all modifier codes (i.e., Minimum Data Set (MDS) clinical assessment time frames) must have an equal likelihood of being selected for review.

-- FIs are to select bills each month for postpayment review based on date of service.

b. Focused Medical Review--In addition to the random review, FIs are to continue focused medical review (FMR) according to MIM §3939. We do not want FMR for aberrant providers to be reduced because of SNF PPS -- though it must be done on a postpayment basis once the provider has transitioned to the PPS.

- FMR Bill Selection--In selecting their overall workload, an FI may choose specific claims or target providers with high error rates or newly participating providers. However, this targeted portion of the review must not exceed 20% of the negotiated SNF PPS claims workload reviewed by each FI. If an FI determines that it is necessary to perform FMR at a level beyond 20% of their negotiated workload, the FI should contact its Regional Office (RO) to determine what other workload/budget options may be necessary to accommodate these focused medical reviews.

-- It is necessary for the FI to validate that suspected problems exist before reviewing an increased level of a specific provider's claims. Follow the guidelines in MIM §3939 when making this determination. In addition, HCFA may be directing targeted reviews based on data obtained from the HCFA Repository or other sources.
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c. Demand Bills--Continue mandated review of SNF demand bills. Demand bills will be submitted as usual, indicating that the beneficiary requested the noncovered claim be submitted to the fiscal intermediary for consideration. 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. 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, pay at the RUG-III code billed for the number of days you have determined to be covered. Follow the medical review instructions to determine that the services were reasonable and necessary and use the RUG-III Adjustment Matrices (EXHIBIT II) to adjust the RUG-III code if necessary. Report workload and savings information on the Report of Benefit Savings (EXHIBIT V) according to the instructions in section G below.

2. Bill Review Requirements--FIs must conduct review of SNF PPS bills in accordance with current SNF bill review instructions. This includes all applicable MIM sections, FI standard operating procedures for soliciting additional documentation, time limitations for receipt of the solicited documentation, claim adjudication, and recoupment of overpayment. Supplementary requirements have been added to the review of SNF PPS bills. These additional supplementary requirements are listed below:

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

b. A Health Insurance Prospective Payment System (HIPPS) code must also be on the bill. This is a five digit code. The first three digits are an alpha/numeric code identifying the RUG III classification. The last two digits are numeric indicators of the reason for the MDS assessment.

c. 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. Each MDS submitted with the medical record is to be signed.

3. Bill Review Process

a. **Request Records**--Request 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 with a signature page. You must also request documentation to fully support each MDS, 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; patient assessment instrument (MDS); nursing and rehabilitation therapy notes; and treatment and flow charts and vital sign records, weight charts and medication records (See MIM §3900).

- 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 post payment 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 prepayment review of demand bills, continue current prepayment operating procedures if the provider fails to furnished 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, HCFA-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. Base your review on the following:

-- HCFA 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.

- **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 Determination Case Examples.

It is important to remember that if the medical record supports that (1) services were delivered as documented on the MDS, and (2) that such services were reasonable and necessary during the relevant assessment period, the billed RUG-III group should be accepted for payment. It is also 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.

We are not currently focusing our MR efforts on whether significant change assessments are taking place in between required assessments. According to the Long Term Care Resident Assessment Instrument (RAI) User's Manual, SNFs should be conducting reassessments when significant changes occur in a beneficiary's condition or treatment. For Medicare beneficiaries in Part A stays, any such change may also affect the billed HIPPS code. We will be working with providers and contractors to develop further guidance for medical reviewers regarding the appropriate use of off-cycle assessments such as the Significant Change in Status Assessment (SCSA), in the coming months. This guidance will include information on Asignal events@ that medical reviewers could look for in determining whether the SNF should have performed an off-cycle (SCSA or Other Medicare Required Assessment) assessment to reflect a change in the beneficiary's clinical condition. Pending such guidance, if the FI questions the necessity of some services taking place between regular

assessments, the FI is only to make appropriate payment adjustments for situations involving a beneficiary's discharge from the facility for reasons other than a temporary visit home or if all therapies have been discontinued by the physician

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 HCFA's Fraud and Abuse guidelines (MIM §3950).

4. Outcome of Review

a. For all HIPPS codes billed, if you determine that the billed RUG-III group(s) are reasonable and necessary and meets the level of care criteria, accept the claim as billed.

b. For HIPPS codes indicating rehabilitation services, if you determine that the rehabilitation services were appropriate, but not at the level billed, adjust the billed RUG-III code according to Matrix A of RUG-III Adjustment Matrices, EXHIBIT II.

c. If all rehabilitation services are determined to be medically unnecessary, 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.

d. For all HIPPS codes billed, 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 MIM §3950.

e. For HIPPS codes billed indicating classification into the lower 18 RUG-III groups, if the beneficiary did not meet the SNF level of care requirement, deny the bill in full for the entire payment period.

f. For all HIPPS codes billed, if you determine that the beneficiary falls to a non-skilled level of care, discontinue Medicare coverage effective when the beneficiary no longer meets level of care criteria.

g. 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.

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 and are subject to appeal rights.

C. New Medicare Summary Notice (MSN) Message--When reviewing demand bills, if it is noted that the beneficiary is receiving a skilled level of care in a non-certified bed, it is necessary to determine whether or not the beneficiary received appropriate notice. The notice issued by the provider must state the implications of being placed in a non-certified bed. If the implications are not clearly stated, the notice is deemed invalid and the provider should be held liable for the care. We have created the following new MSN message to use in this situation:

Improper Placement in a Non-Certified Bed

MSN 3.17 - Normally, care is not covered when provided in a bed that is not certified by Medicare. However, since you received covered care, we have decided that you will not have to pay the facility for anything more than Medicare coinsurance and noncovered items.

The Spanish version should read as follows:

Normalmente, servicios de cuidado de salud no están cubiertos cuando son proporcionados en Una cama que no está certificada por Medicare. Sin embargo, como usted recibió servicios de cuidado de salud que sí estaban cubiertos, decidimos que no tiene que pagarle a la institución nada más que el seguro complementario y los artículos y servicios que Medicare no cubre.

For a complete list of MSN and ANSI messages pertaining to SNF PPS, see EXHIBIT IV.

D. Workload--All FIs must review SNF PPS bills. This includes performing postpayment random and continued focused reviews. PM A-99-20 instructed FIs that the target review level should be 1 - 3% of the total SNF PPS inpatient claim volume. HCFA recognizes that the delay in medical review of SNF PPS claims during the first quarter of FY 2000 may create difficulty in meeting FY 2000 negotiated workload levels. Thus, **for FY 2000 only**, the minimum acceptable review level for SNF PPS claims is decreased to .5%. Additionally, to accommodate the workload adjustments, uneven distributions of SNF PPS MR workload during the first half of FY 2000 will not impact your FY 2000 Contractor Performance Evaluation.

FIs are not prohibited from reviewing more SNF PPS bills than projected, however, they must consult their Regional Office before reviewing above the negotiated review level.

SNF PPS workload requirements for FY 2001 will be defined in the annual Budget Performance Requirement process.

E. Data Analysis--The random postpayment review of SNF PPS bills will assist in identifying normal practice patterns, aberrancies, potential areas of overutilization, and patterns of noncovered care. This MR activity should add a strong foundation for focused medical review of claims. FIs should begin evaluating and developing their SNF PPS focused medical review criteria. As indicated in MIM §3939, continue data collection and analysis of SNF PPS billing information, data from other Federal sources (PROs, 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.

F. MIP-PET--The SNF PPS is a new payment methodology and we believe 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 the random 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 MIP-PET CAFM2 code 24001.

G. Savings--Savings resulting from the review of SNF PPS bills are to be reported in the Report of Benefit Savings (RBS), according to MIM §2301--SNF PPS. Use the following method to capture savings on the RBS for SNF PPS.

- Screens on the RBS that are affected for capturing savings for SNF PPS and SNF Non-PPS are 1, 2, 4 and 5. (EXHIBIT V)

- Presently, we capture SNF Non-PPS savings on screens 1 and 2, on lines 5, 7, and 17. For this reason, the definition we currently use will be modified to clarify that the data reported on these line items are for SNF Non-PPS activity, exclusively.

- The conversion factor will be changed in the system to reflect the SNF Non-PPS rate, which is $227.00. This rate was obtained from the Office of the Actuary. This rate will remain in effect until such time that the Office of the Actuary provides conversion factors for FY 2001.

- Screen 5 of the RBS allows the contractor to place the data in manually. For this reason, we have selected line one and two of the remarks section to be used for capturing the number of bills reviewed, the number of days denied, the cost and the dollar amount saved (category 16 of page one of the RBS)for SNF PPS days, and SNF PPS demand days.

- The conversion factor for the SNF-PPS is $233.72. This rate was obtained from the Office of the Actuary and will be updated for FY 2001.

- When calculating the dollar amount of SNF PPS days denied and/or reduced multiply that number by the SNF PPS conversion factor, which is $233.72. For example: If the number of days denied and/or reduced equals 100, then you would multiply that number by $233.72. This would result in a figure of $23,372.

H. Reporting-- FIs are to report each month (**not cumulative**) the information requested in the SNF PPS Postpayment Medical Review Report (EXHIBIT VI). This report will be sent to you in an Excel 5.0 file. Continue to utilize the FMR Activity Report for non-SNF PPS medical review activity.

Instructions for Completing SNF PPS POSTPAY MR REPORT:

Total Bills Paid
# of bills - This represents the total # of SNF PPS bills that were paid during the month and should be obtained from your payment system.
# of days - This represents the total # of days that were paid during the month for SNF PPS and should be obtained from your payment system.
$ amount reimbursed - This represents the reimbursement amount paid during the month for SNF PPS and should be obtained through your payment system.

Total Bills Reviewed
# of bills - Report the actual # of SNF-PPS claims that were reviewed during the month.
# of days - Report the total # of days that were billed on SNF PPS claims that were reviewed during the month.
Reimbursement $ amount reviewed - Report the total $ amount reimbursed on the SNF PPS claims that were reviewed during the month. This is the reimbursement amount associated with revenue code 0022.

RESULTS OF RANDOM POSTPAYMENT MEDICAL REVIEW - Report in the columns under this heading the results of your postpay medical review activities for all SNF PPS claims reviewed during the month that were selected Randomly. Do not include in this section any claims that were specifically selected because of a known problem. These claims should be reported in the Focused section of this report.

RESULTS OF FOCUSED POSTPAYMENT MEDICAL REVIEW - Report in the columns under this heading the results of your postpay medical review activities for all SNF PPS claims reviewed during the month where the selection process of the claims focused on a specific problem or a specific provider. Do not include in this section any claims that were randomly selected. These claims should be reported in the Random section of this report.

Below are the definitions of the columns under both the Random and Focused sections of this report. Use these definitions to report, in their respective sections, the results of your random and focused medical review activities for SNF PPS claims.

Bills Paid in Full

# of bills - Report the # of SNF PPS bills that were reviewed during the month that required no adjustments.

# of days - Report the # of days that were billed and paid on SNF PPS claims that were reviewed during the month and required no adjustment.

$ amount reimbursed - Report the amount reimbursed on the SNF PPS bills that were reviewed during the month and required no adjustment.

Bills Denied - Insufficient Documentation

# of bills - Report the # of SNF PPS bills that were reviewed during the month and were denied in full or in part because requested documentation received was insufficient or not submitted.

# of days - Report the # of days billed on SNF PPS bills that were reviewed during the month and denied in full or in part because requested documentation were not submitted.

Reimbursement $ amount denied - Report the reimbursement amount being denied, on SNF PPS claims reviewed and denied in full or in part during the month, because the required MDS assessments were not submitted. This is the reimbursement amount for revenue code 0022 in the FSS or the Arkansas system for the MDS period being denied.

Bills Denied - Not Reasonable and Necessary

# of bills - Report the # of SNF PPS bills that were reviewed during the month and denied in full or in part for any reason other than insufficient documentation (i.e., services were not reasonable and necessary).

# of days denied - Report the # of days that were denied during the month because of a full or partial denial of a SNF PPS bill for any reason other then insufficient documentation (i.e., services were not reasonable and necessary).

Reimbursement $ amount denied - Report the reimbursement amount being denied because SNF PPS bills reviewed during the month were denied in full or in part for any reason other than insufficient documentation (i.e., services were not reasonable and necessary). To compute this amount multiply the # of days denied by the rate for revenue code 0022, as determined by the FSS or Arkansas system, for the days being denied.

Bills Paid At an Adjusted RUG III Code

# of bills - Report the # of SNF PPS bills that were reviewed during the month where either the entire bill or part of the bill was paid at an adjusted RUG III code.

# of days reduced - Report the # of days that are being paid at an adjusted RUG III code because either the entire bill or part of the bill was reduced because inappropriate RUGs were billed.

$ amount saved - Report the amount of savings related to adjusting the RUG III code billed. This savings should be calculated by subtracting the total federal rate for the new RUG category from the total federal rate for the category originally billed (The federal rates for FY 1999 were published in the IFR. Updates to the federal rates will be published in the Federal Register before August 1 of each fiscal year). Multiply this result by the # of days that were reduced (i.e., for FY 1999, if 5 days were reduced from RUC to RMC, the calculation would be $384.21-267.34 = $116.87; $116.87 times 5 days = $584).

Within 30 days after the close of each month, submit one copy of the report to your regional office and one copy to central office at the address below:

Health Care Financing Administration
Office of Financial Management
Attn: Program Integrity Group
Mail Stop: C3-02-16
7500 Security Boulevard
Baltimore, MD 21244-1850

You may send the report electronically to the central office corporate ID at SNFPPSREPORTS@hcfa.gov.

Effective date: The instructions for SNF PPS postpay medical review in this PM are effective for claims with dates of service on or after October 1, 1999. The MSN portion will be effective July 1, 2000.

Implementation date: The instructions for SNF PPS postpay medical review in this PM should be implemented upon receipt. The MSN portion should be implemented July 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2001.

If you have any questions, contact the appropriate regional office.

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), 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)	17-18 15-16 7-14	NOT USED NOT USED NOT USED	SSC SSB SSA
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	Nursing Rehabilitation*	IB2
	6-10	not receiving	IB1
	4-5	Nursing Rehabilitation	IA2
	4-5	not receiving	IA1
BEHAVIOR ONLY			
Coded on MDS 2.0 items:	6-10	Nursing Rehabilitation*	BB2
4+ days a week - wandering, physical or verbal abuse,	6-10	not receiving	BB1
inappropriate behavior or resists care;	4-5	Nursing Rehabilitation	BA2
or hallucinations, or delusions checked	4-5	not receiving	BA1
PHYSICAL FUNCTION REDUCED	16-18	Nursing Rehabilitation*	PE2
	16-18	not receiving	PE1
No clinical conditions used	11-15	Nursing Rehabilitation	PD2
	11-15	not receiving	PD1
	9-10	Nursing Rehabilitation	PC2
	9-10	not receiving	PC1
	6-8	Nursing Rehabilitation	PB2
	6-8	not receiving	PB1
	4-5	Nursing Rehabilitation	PA2
	4-5	not receiving	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. Please 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

Medical Review Determination Case Examples

EXAMPLE 1--A Medicare beneficiary classified into the SE1 RUG-III group based on his Medicare required 5 day assessment(ARD on day 6). The provider billed for days 1 through 14 at the SE1 rate, On review of the medical record documentation, the reviewer finds that the beneficiary classified into the SE1 group based on his ADL score of 8 and his receipt of IV medications during his acute care hospital stay. He received no IV medications during his SNF stay, but did receive an anticoagulant by sub-cutaneous injection for which he required close monitoring, teaching to prepare him for discharge to his home and daily lab tests. According to the documentation supplied by the facility, skilled services were provided through day 22 of his stay. The bill would not be adjusted. The bill would be paid in full for the entire payment period (days 1 through 14). Classification into the SE1 group is legitimate and the beneficiary is receiving daily skilled care, although, perhaps not at the level the reviewer might expect to see at the SE1 classification**.**

EXAMPLE 2--A Medicare beneficiary classified into the SSA RUG-III group based on her Medicare 14 day assessment. Her MDS reflects a surgical wound and dressing changes, tube feeding (and receiving 51 percent of daily calories through the tube), aphasia, hemiplegia, and an ADL score of 12. However, there is no documentation to support that the requirement for tube feeding was met, nor is there any supporting documentation for the provision of surgical wound dressing changes. The documentation does clearly support that the beneficiary is receiving skilled monitoring and evaluation by the nursing staff. In this case, the reviewer should adjust the claim according to Matrix B. Once the medical reviewer disallows the tube feedings and dressing changes reported on the MDS, the beneficiary no longer qualifies for the Special Care category. However, she is a hemiplegic with an ADL score greater than 10 who continues to require daily skilled monitoring and evaluation and so does qualify for classification into the Clinically Complex category. The bill would be adjusted for payment at the CA1 level for the entire 16 day payment period.

EXAMPLE 3--A Medicare beneficiary was classified into the RUA RUG-III group based on his Medicare required 5 day assessment. On review it was determined that two of the three rehabilitation therapy disciplines provided were not reasonable and necessary for this beneficiary. This determination was based on the fact that there was no documentation to indicate that the beneficiary had any communication or swallowing problems that would support the need for speech and language therapy services. Likewise, there was no documentation to indicate any functional deficits that supported the need for occupational therapy services. However, the amount of physical therapy provided was determined to be appropriate. Therefore, using Matrix A, the reviewer adjusted the RUG-III code billed to RMA for the entire payment period. This reclassification of the beneficiary is legitimate even with the new Medicare presumption of coverage policy. Although the beneficiary is presumed to meet the level of care criteria for Medicare coverage, there is no presumption that services that are provided, and that serve as criteria for classification, are reasonable and necessary.

EXAMPLE 4--A Medicare beneficiary was classified into the RUA RUG-III group. The beneficiary's deficits were impaired strength and endurance related to a medical condition, in this case, pneumonia. On medical review the reviewer determines that the beneficiary had no medically reasonable and necessary requirement for rehabilitation therapy services, because his deficits would be expected to spontaneously improve as the beneficiary resumes normal activities. There was no documentation to indicate that there were any medical conditions to support the need for rehabilitation therapy services. In this case, the reviewer would disallow all rehabilitation therapy services and use Matrix B to adjust payment for the entire payment period. The reviewer would reclassify the bill from RUA to the CA1 group based on his pneumonia diagnosis and the daily skilled care being provided for this condition that was documented in the nurses' notes. The bill would be adjusted for the entire payment period.

EXAMPLE 5--An insulin-dependent diabetic Medicare beneficiary was classified into the RHB RUG-III group based on his Medicare required 14 day assessment. The beneficiary had a fever and was dehydrated. On review, there was no documentation to support the need for rehabilitation therapy services and it was determined that no rehabilitation therapy was medically reasonable or

necessary. The beneficiary is clearly in need of daily skilled nursing service, however. Based on her fever with dehydration and frequent fluctuation in her daily blood sugar test results, using Matrix B, the medical reviewer adjusted the bill to the SSA level for the entire payment period.

EXAMPLE 6--Based on his 14 day Medicare assessment a beneficiary was classified into the SSB RUG-III group based on his ADL sum score and fever with dehydration. He also was an unstable, insulin-dependent diabetic with four order changes and physician visits in the past two weeks. On review of the medical record, the reviewer found no documentation of treatment for dehydration but there was a sustained level of skilled monitoring, as evidenced by daily blood sugar testing and nursing notes, and evaluation by the nursing staff. Using Matrix B, the bill was adjusted for the entire 16 day payment period to the CB1 level.

EXAMPLE 7--On the 5 day assessment (ARD day 7), the beneficiary was classified into the RLB RUG-III group. He lost range of motion in his right arm, wrist and hand several years ago, due to a CVA. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the OT fabricated a right resting handsplint and instructions for its use. The OT saw the beneficiary three times each week for splint fabrication, monitoring and teaching nursing staff and family members. The RN developed instructions for providing passive ROM exercises to his right arm, wrist and hand 3 times per day. The CNA s have been instructed on how and when to apply and remove the handsplint and how to do the passive ROM exercises. These plans are documented in the care plan and the beneficiary's progress is documented in the medical record. The classification is appropriate and the bill is paid in full for the entire period.

EXAMPLE 8--A facility submitted a demand bill at the SSB payment level on behalf of a Medicare beneficiary who has multiple sclerosis (MS) and an ADL score of 15. As evidenced by his 14 day MDS and the rest of the medical record documentation, during the first part of his SNF stay the beneficiary required surgical wound dressing changes and IV antibiotics. By the 30 day assessment, however, he stabilized and no longer required a Medicare skilled level of care. The SNF issued a written notice of noncoverage on day 28 of the stay. The beneficiary's family requested that a demand bill be generated because the beneficiary qualifies for one of the upper 26 RUG-III groups due to his MS and high ADL score. The family is not concerned about using all of the beneficiary's Medicare SNF benefit days. The reviewer upheld the facility's decision and denied the claim for the entire payment period. Even though the beneficiary will continue to qualify for classification into the SSB RUG-III group based on his chronic clinical diagnosis and the ADL score, he is no longer in need of skilled services. The Medicare SNF benefit only is intended to cover skilled care.

EXAMPLE 9--A facility submitted a demand bill for a beneficiary who classified into the BA1 RUG-III group. He was verbally abusive, and wandered most of every day. Nursing rehabilitation services were not provided. The beneficiary's family requested that a demand bill be sent by the facility. The medical reviewer upheld the facility's decision and denied the bill for the entire payment period.

EXHIBIT IV

Medicare Summary Notice / ANSI Messages

Insufficient Information Denial

MSN 9.2
"The item/service was denied because information required to make payment was missing"
ANSI A1 &B12
"Claim denied charges" and "Services not documented in patient's medical records"

Partial Payment at Reduced Rate (Matrix)

MSN 15.8
"The information provided does not support the level of service as shown on the claim."
ANSI A1 and 57
"Claim denied charges" and "The claim/service denied/reduced becausethe payor deems the information submitted does not support this level of service/this many services/this length of service or this dosage."

Full Denial as Not Medically Reasonable and Necessary

MSN13.3 or 13.4
"Information provided does not support the need for skilled nursing facility care."
or
"Information provided does not support the need for continued care in a skilled nursing facility."
ANSI A1 and 50
"Claim charges denied" and "These are noncovered services because this is not deemed a medical necessity by the payor."

Demand Bills

Agreeing with noncoverage:
MSN 16.2
"The provider's determination of noncoverage is correct."
ANSI A1 and 50
"Claim charges denied" and "These are noncovered services because this is not deemed a medical necessity by the payor."

Agree with noncoverage but the provider failed to issue proper or timely notice:
MSN 36.2
"It appears that you did no know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things:

a) a copy of this notice
b) your provider's bill
c) a receipt or proof that you have paid the bill.

You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility."
ANSI 116
"Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements."

Improper Placement in a Non-Certified Bed:
MSN 3.17
“Normally, care is not covered when provided in a bed that is not certified by Medicare. However, since you received covered care, we have decided that you will not have to pay the facility for anything more than Medicare coinsurance and noncovered items.”
ANSI 116
"Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements."

<u>Billing Error</u>

MSN 9.2
"Information required to make payment was incorrect."
ANSI A1
"Claim denied charges"

Screens 1 and 2 of the Report of Benefit Savings Definitions

Line Item	Present -- Screens 1 and 2	Revised -- Screens 1 and 2
5	**SNF Days** Definition: Inpatient days determined to be noncovered.	**SNF Non-PPS Days** Definition: Inpatient non-PPS days determined to be noncovered.
7	**SNF Ancillary Charges** **Definition**: Noncovered ancillary services billed under Part B for a SNF inpatient; Ancillary services denied on a Part A bill for SNF inpatient.	**SNF Non-PPS Ancillary Charges** Definition: Noncovered SNF-Non PPS ancillary services billed under Part B for a SNF inpatient; Ancillary services denied on a Part A bill for SNF inpatient.
17	**SNF Demand Days** **Definition**: SNF days determined to be noncovered by provider, and you concur.	**SNF Non-PPS Demand Days** **Definition**: SNF non-PPS days determined to be noncovered by provider, and you concur.

Screen 4, Line item 3, MR cost and number of bills reviewed

Present Definition for Line Item 3 of Screen 4	Revised Definition for Line Item 3 of Screen 4
SNF	SNF(PPS & Non-PPS)

Screen 5, Line item 2, Other Audits, of the Report of Benefit Savings Definitions

	Present Definitions for Lines 2 of Screen 5.	Revised Definitions for Line 2 of Screen 5.
	OP HOSP. AUDITS	Definition: Other Audits

Screen 5, REMARKS SECTION, Line Items 1 and 2 of the Report of Benefit Savings

REMARKS:

1. **SNF PPS, NUMBER OF BILLS, NUMBER OF DAYS DENIED, $ COST, AND $ SAVINGS (CATEGORY 16)**
2. **SNF PPS-DEMAND, NUMBER OF BILLS, NUMBER OF DAYS DENIED, $ COST, AND $ SAVINGS (CATEGORY 16).**

Category Revisions to the Report of Benefit Savings to Capture Non-PPS Savings

Current Categories	Revised Category Revisions and Bill Types
1 -- Hospital PPS	1 -- Hospital PPS - 11x
2 -- Hosp. Non-PPS	*2 -- Hosp. Non-PPS - 11x
3 -- Hosp. Outpatient	*3 -- Hosp. Outpatient - 13x- 43x - 83x - 85x
4 -- Hosp. Ancillary -- IP	*4 -- Hosp. Ancillary -- IP - 12x
5 -- SNF Days	*5 -- SNF Days Non-PPS - 18x - 21x - 28x - 51x
6 -- SNF Outpat. Chg	*6 -- SNF Outpat. Chg. - 23x - 53x
7 -- SNF Ancill. Chg	*7 -- SNF Non-PPS Ancill. Chg - 18x - 21x - 22x - 52x
8 -- ESRD	*8 -- ESRD - 72x
9 -- Outpat. PT/Rehab	*9 -- Outpat. PT/Rehab - 74x - 76x
10 -- CORF	*10-- CORF - 75x
11 -- Rural Hlth Ctr.	*11-- Rural Hlth Ctr - 71x
12 -- Other Part B	*12 -- Other Part B -14x-24x-42x-44x-54x-73x-76x
13 -- Program Integrity Savings	13 -- Program Integrity Savings - ALL BILL TYPES
14 -- Open Biopsy	14 -- Open Biopsy- 11X(OPEN VS CLOSED BIOPSY)
15 -- O/P Hosp. Audit	15 -- ALL AUDITS - ALL BILL TYPES
16 -- Other Audits	*16 -- SNF PPS/SNF PPS DEMAND-18X-21X-28X-51X
17 -- SNF Demand Days	*17--SNF Non-PPS Demand Days-18X-21X-28X-51x
18 -- HHA S.N. Visit	18 -- HHA S.N. Visit-32X-33X REV CODE 55X
19 -- HHA S.T. Visit	19 -- HHA S.T. Visit-32X-33X REV CODE 44X
20 -- HHA P.T. Visit	20 -- HHA P.T. Visit-32X-33X REV CODE 42X
21 -- HHA Aide Visit	21 - HHA Aide Visit Visit-32X-33X REV CODE 57X
22 -- HHA O.T. Visit	22 -- HHA O.T. Visit - 32X-33X REV CODE 43X
23 -- HHA M.S.S. Visit	23 -- HHA MSS Visit - 32X-33X REV CODE 56X
24 -- HHA DME & Supplies	*24 -- HHA DME & Supplies - 32X-33X REV CODE 26X-27X-29X
25 -- OP Home Health	*25 -- OP Home Health - 34X
26 -- Hospice	26 -- Hospice - 81X - 82X
27 -- CCR S.N. Visit	27 -- CCR S.N. Visit -32X-33X REV CODE 55X
28 -- CCR S.T. Visit	28 -- CCR S.T. Visit -32X-33X REV CODE 44X
29 -- CCR P.T. Visit	29 -- P.T. Visit -32X-33X REV CODE 42X
30 -- CCR Aide Visit	30 -- CCR Aide Visit -32X-33X REV CODE 57X
31 -- CCR O.T. Visit	31 -- CCR O.T. Visit 32X-33X REV CODE 43X
32 -- CCR M.S.S. Visit	32 -- CCR MSS Visit-32X-33X REV CODE 56x

***Applicable Deductible and Coinsurance Amounts apply to each of these categories.**

EXHIBIT VI (Excel file “A-00-08a.xls -- Attached)

FY 1999 SNF PPS RANDOM POSTPAYMENT MEDICAL REVIEW DRAFT
FOR THE MONTH OF ____________________________________

Tracking Log

						Results of Random Postpayment Medical Review					
Identifying Information				Bills Reviewed		Bills paid in full		Bills Denied in Full MDS Not Submitted		Bills Denied in Part MDS Not Submitted	
ITEM #	HICN #	DCN #	DOS	#of days rev	reimb $ amount reviewed	#of days paid	$ amount reimb	# of days denied	reimb. $ amount denied	# of days denied	Comp. $ amount denied
1	123456789A	1234567899876	9/1-9/15/98	15	4000			15	4000		
2	234567890A	1234567899988	7/1-7/17/98	17	5000						
3	123321111A	1234567897786	9/6-9/30/98	25	8000	25	8000				
4	987654321A	1234567868781	8/1-8/13/98	13	6000						
5	456456456A	1234567847778	8/2-8/20/98	19	6000						
6	123789456A	1234567844445	8/1-8/11/98	11	4000						
7											
8											
9											
10											
11											
12											
13											
	Total			100	$33,000	25	$8,000	15	$4,000	0	$0

FY 2000 SNF PPS RANDOM POSTPAYMENT MEDICAL REVIEW DRAFT
FOR THE MONTH OF ______________________________

Tracking Log

Results of Random Postpayment Medical Review

	Bills Denied in Full Reasons Other than MDS		Bills Denied in Part Reasons Other than MDS		Entire Bill Paid at the Default Rate		Partial Bill Paid at the Default Rate	
ITEM #	# of days denied	reimb. $ amount denied	# of days denied	Comp. $ amount denied	# of days denied	$ amount saved	# of days denied	$ amount saved
1								
2	17	5000						
3								
4			8	1500				
5					19	6000		
6					11	4000		
7								
8								
9								
10								
11								
12								
13								
Total	17	$5,000	8	$1,500	30	$10,000	0	$0