CHAPTER 1: CLINICAL CRITERIA

OVERVIEW

PPS Final Rule

- **Effective service dates on and after 10/1/99**

The final rule (FR) for SNF PPS for fiscal year 2000 is effective for service dates on or after October 1,1999. The FR represents some additional changes to the SNF Extended Care Benefit, with respect to coverage eligibility and clinical criteria. The following represents both new and clarified information from the FR.

ELIGIBILITY CRITERIA

The long-standing administrative criteria for coverage under the Extended Care Benefit remains. Under the FR an addition to the definition of a skilled level of care has been made.

Eligibility Criteria

Technical Eligibility Requirements

Technical eligibility remains per the Medicare Intermediary Manual (MIM-3) and the Skilled Nursing Facility Manual (HIM-12).

- Enrolled in Medicare Part A and has days available to use
- Three-day qualifying stay prior hospital stay
- Thirty-day transfer

Clinical Eligibility Requirements

A beneficiary is eligible for post hospital extended care if the following requirements are met:

- Beneficiary's need for and receipt of skilled care on a daily basis provided by or under the direct supervision of skilled nursing or rehabilitation professionals

- As a practical matter these skilled services can only be provided in a SNF

- Services must be needed for a condition which was treated during the patient's qualifying stay
  or
  for a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in a hospital

PHYSICIAN CERTIFICATION

Physician Certification

- **Required**
- **Has no bearing on certifications required for therapy plans of treatment**

A physician, clinical nurse specialist or nurse practitioner must certify and re-certify every thirty days, where such services are furnished over a period of time, the need for extended care services in the SNF.

The initial certification, a prerequisite to the admission, may be to one of the following:

- Certify in the existing context found in 42 CFR 424.20 that the resident meets the existing SNF level of care definition, or

- A statement that the resident's assignment to one of the upper RUG-III (Top 26) groups is correct.

Recertifications are to the continued need for skilled extended care services.

These certification statements have no correlation to requirements specifically related to the plan of treatment for therapy that is required for purposes of coverage.

Spell of Illness

- **No break in a spell of illness if resident is in top 26 RUG-III groups**

SPELL OF ILLNESS

A SNF resident who has exhausted Part A benefits continues to meet the skilled level of care definition when placing in the top 26 RUG-III groups. As a result, there is no break in the spell of illness.

THE BASIC COMPONENTS OF SNF PPS-THE MINIMUM DATA SET (MDS) AND THE RUG-III GROUPS

MDS and RUG-III GROUPS

- **No alteration in the MDS completion requirements or**
- **The composition of the RUG-III Groups**
- **Clarifications on:**

- **Grace days**
- **Competition/locking**
- **Section U**
- **OMRAs**

The FR has not changed the requirements for the completion of the MDS or the make-up of the RUG-III clinical groups, but merely clarified them based on comments given to the IFR.

THE MINIMUM DATA SET (MDS) VERSION 2.0 AND THE RUG-III GROUPS

As stated in the IFR, the MDS is a clinical assessment tool, representing the primary source of quality indicators, and provides the basis for the RUG-III classification system and the PPS.

The final rule did not alter any of the item definitions of the MDS nor any of the requirements for its performance on a designated schedule. However, the following areas were clarified:

- Grace days
- Performance and locking requirements

- Section U
- Other Medicare Required Assessments (OMRA)

Grace Days

Grace Days
- **Acceptable and permitted**

Under the requirements of the IFR, a specific number of grace days are allowed for each scheduled Medicare assessment. (Refer to MDS Assessment Schedule). **The final rule has not altered the number or use of grace days but has clarified their use and application.** The use of grace days is acceptable and permitted for patients with any condition.

The Medicare Five-Day Assessment and the Use of Grace Days

Days one through five are optimal Assessment Reference Dates (ARD): however, days six through eight are also acceptable and for some residents, (e.g.,those receiving rehabilitation services) the most appropriate.

Grace Days and Rehabilitation

Grace Days and Rehabilitation

- **Acceptable for 5 Day ARD to fall within the grace days**

A specific number of grace days are allowed for setting the assessment reference date (ARD) for each scheduled Medicare assessment.

There are three principal reasons for the use of grace days:

1. Allows for the situation where the beneficiary is not able to begin therapy at the time of admission due to an unstable condition and does not begin receiving a therapy program until days 5, 6, or 7 of the SNF stay. In order to capture the rehabilitation therapy necessary for the beneficiary's classification into one of the rehabilitation therapy RUG-III groups, the facility will choose to set the ARD on one of the grace days.

2. Allows for the classification into one of the two highest RUG-III sub categories of Ultra High and Very High by capturing the minimum level of

services received by the beneficiary in the first seven days of his or her stay.

3. Allows clinical flexibility in setting ARDs.

Reminder:

If a facility chooses to routinely use grace days, it may be subject to audit to determine if indeed the assessment reference dates are accurately reflected.

Section U

Section U

- **Deferred Indefinitely**

As noted under the FR, requirements for completion of Section U (Medications) are deferred indefinitely.

Completion and Locking

Competition and Locking

- **An MDS must be signed by all team members within 14 days of the ARD**
- **A Medicare claim may not be submitted until after the MDS has been locked**

As for all MDS assessments, those performed for Medicare beneficiaries must be performed according to the clinical rules. This means that the MDS should be completed (signed by all team members) within 14 days of the ARD indicated in item A3a.

- The completion date indicated in MDS item R2b must be within 14 days of the date entered in A3a.
- The assessment must be locked within 7 days of the date indicated at item R2b
- Transmitted to the state within 31 days of the final lock date.

Example: ARD = 10/6/99
Completion Date = 10/19/99
Locked By 10/25/99

Reminder:
Only those assessments that have been locked may have a bill prepared and submitted for payment to the Fiscal Intermediary (FI) for Medicare payment.

MDS Corrections

Corrections Policy is set forth in the MDS 2.0 User Guide, MIM-3 and Program Memorandum A-00-46 entitled "Skilled Nursing Facility Adjustment Billing: Adjustments to HIPPS Codes resulting from MDS Corrections".

THE OTHER MEDICARE REQUIRED ASSESSMENT (OMRA)

The Other Medicare Required Assessment

- **Must be completed if a skilled level of care is ongoing**
- **The ARD must be set on days 8, 9 or 10**
- **Rehabilitation RUG rate continues from therapy end to OMRA ARD**

The OMRA **must be completed only if the beneficiary continues to have a skilled level of care** requirement after the discontinuation of therapy. The OMRA assessment reference date must be set on day 8, 9 or 10 after the last day of all rehabilitation.

- Coverage continues at the rehabilitation rate to which the beneficiary classified from the end of therapy until the OMRA assessment reference date.
- If the beneficiary is discharged or no longer needs a skilled level of care before the eighth day following the end of therapy, no OMRA is required.

Reminder:
Always waiting to verify the stability of the beneficiary in the absence of skilled nursing or rehabilitation is not appropriate.

MAKING A LEVEL OF CARE DETERMINATION

Skilled Level of Care

A prerequisite for coverage under the extended care benefit is the beneficiary's need for and receipt of a skilled level of care and the fact that all services must be reasonable and necessary to diagnose or treat the beneficiary's condition.

Final Rule for Fiscal Year 2000

The FR redefined and further clarified the definition of skilled care by establishing a 5-day presumption of coverage. It is usually during this period immediately following post-hospitalization that a beneficiary's condition is most unstable. During these initial days of the SNF stay, staff will:

Skilled Level of Care and the FR Fiscal Year 2000

- **Established 5-Day presumption for meeting a Skilled Level of Care**

- Initiate skilled nursing and or rehabilitation
- Complete assessment of the beneficiary's clinical characteristics and care needs

However, this presumption of coverage only applies if the beneficiary is receiving services that are reasonable and necessary to diagnose or treat the beneficiary's condition.

Five Day Presumption

- **Requires placement in Top 26 RUG-III groups**
- **Services must be reasonable and necessary**
- **Applies to Medicare 5-Day assessment only**
- **Extends from admission up to and including the ARD and grace days if utilized**

Definition of the 5-Day Presumption

When the initial Medicare required assessment (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 admission up to and including the ARD for that assessment.**

This presumption is valid through the ARD of the 5 day assessment.

Determination of Skilled Care Beyond the 5 Day Presumption

Continuation of coverage once established by the RUG-III presumption is dependent upon the subsequent course of the resident's actual condition and care needs as documented in the medical record.

The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the beneficiary's condition and care needs, thus meeting the skilled care definition. If the services are not medically necessary, a decision of non-coverage should be made.

FR Coverage Criteria is effective for Service Dates on or after 10/1/99

Additions to Existing Administrative Criteria

- **Management and Evaluation of A Care Plan**
- **Observation and Assessment**

Additions to the Existing Administrative Criteria under the IFR:

- Overall management and evaluation of a plan of care
- Observation and assessment of a patient's condition

Modifications to Existing Criteria

- **Catheters have been modified to suprapubic catheters only**
- **Patient education to be redefined**

Clarifications

- The qualification of catheters as meeting the definition of direct skilled services has been modified to include suprapubic catheters only.

Skilled observation and assessment

- **Identification and evaluation for treatment plan modifications**
- **Requires skills technical or professional**

SKILLED OBSERVATION AND ASSESSMENT OF THE RESIDENT'S CHANGING CONDITION

"Observation and assessment constitutes skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modifications of treatment or for additional medical procedures until his or her condition is stabilized." (42 CFR 409.33)

Example A

Beneficiary with diagnosis of CHF may require continuous close observation for:

- Signs and symptoms of decompensation
- Abnormal fluid balance
- Medication side effects signaling the need for an adjustment in the medical treatment

Example B

Beneficiary with diagnosis of surgical hip replacement may require observation and assessment for:

- Postoperative complications
- Presence of co-morbid conditions/physical problems
- Acute psychological symptoms such as depression, anxiety or agitation
- To ensure safety of resident in the case of suicidal or homicidal behaviors. **The need for these services must be documented by physicians orders or nursing/ therapy notes.**

OVERALL MANAGEMENT AND EVALUATION OF A CARE PLAN

Management and evaluation of a care plan

- **Based on a physician's order**
- **Requires skilled technical or professional personnel**
- **Overall patient condition must be documented in the medical record to support the need**

The development, management and evaluation of a patient care plan based on physician orders constitutes skilled services when:

- The beneficiary's physical and mental condition requires skilled level technical or professional personnel to safely plan, monitor and manage care.
- The plan involves a variety of personal care services and the aggregate of those services, in light of the patient's condition, requires the involvement of technical or professional personnel

Although a properly instructed person could perform these services, the ability to understand the relationship between services and the ultimate effect of one upon the others is essential. In this circumstance the skills of a nurse are required even though the individual services may not be skilled. (42 CFR 409.33 (i)).

Reminder:
The overall condition must be documented in the medical record to support the finding that recovery and safety can be ensured only if the total care is planned, managed and evaluated by skilled technical or professional personnel.

Example A (Aggregate of Services)

Beneficiary with history diabetes mellitus and angina pectoris is recovering from an open reduction of a fractured femur requiring:

- Skin care per diabetic protocol
- Appropriate oral medications
- Diabetic diet
- Exercise program to preserve muscle tone and body condition
- Observation for signs and symptoms of complication and or deterioration as a result of restricted activity

Patient Education Services

Patient Education

- **For the teaching of a self-maintenance program**
- **Requires technical or professional staff**

Patient education services are skilled when and if the services of a technical or professional person is required to teach a patient a self-maintenance program.

Example

Recent amputee needs skilled rehabilitative services provided by technical or professional personnel to provide the necessary gait training and prosthetic care.

COVERAGE CLARIFICATIONS

Coverage Clarifications

- **MDS Assessments**
- **Rehabilitation Services**
- **Coverage and LOC Determinations**

The FR addressed general concerns and provided clarification or restatement of policy. The following topics were clarified:

- MDS Assessments
- Certification/Re-certifications
- Rehabilitation Services
- Coverage and Level of Care Determinations Effective 10-1-2000
- Ambulance for ESRD beneficiaries
- Midnight Rule

Physician Order Changes and Visits

Physician order changes and visits are indicators of a beneficiary's clinical instability.

Physician Order Changes

The following **are not** order changes:

- Continuation or renewal of existing orders
- Clarifications of existing orders

  A physician's order to continue or renew some specified treatment or regimen is not considered to be an order change, nor would an order written solely to clarify an earlier order

- Sliding scale administrations

  Sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply

because a different dose is administered based on sliding scale guidelines.

Physician Visits

Physician Visits

- **Full or partial exam at the SNF or physician's office**

A physician visit is defined as a partial or full exam at the facility or in physician's office by the following professionals:

- MD, osteopath, podiatrist or dentist
- Primary physician or consultant
- Authorized physician's assistant
- Nurse practitioner working in collaboration with the physician

Rehabilitative Services

Rehabilitative services may begin as early as day one of the beneficiary's Part A stay. All therapeutic services must meet the following criteria to be covered by Medicare Part A:

- Ordered by a physician
- Related directly and specifically to an active written plan of treatment
- Medically reasonable and necessary
- Provided directly or under direct supervision of a licensed professional
- Coordinated with nursing services

Rehabilitative Services and Faxed Signatures

Faxed Signatures

- **Acceptable**

A therapy plan of treatment signed by a physician is acceptable when faxed to the SNF. Any modifications to the original plan must be made in writing, and if done by a therapist, initialed or signed by the ordering physician within a reasonable time.

Initial Evaluations

Initial Evaluations

- **Completed during Part A stay**
- **May not be counted on MDS**
- **Cost captured in the PPS Rate**

The initial evaluation performed by a licensed professional therapist must be completed while the beneficiary is in a SNF Part A stay **and not** be an evaluation that was performed while in the inpatient facility. The time spent by the therapist performing the initial evaluation and subsequently developing treatment goals and a formalized plan may not recorded as minutes of therapy on the MDS. The facility cost of doing the initial evaluation is captured in the SNF PPS rate.

Re-evaluations

The time it takes to perform a re-evaluation may be counted in the therapy Section P of the MDS, if the re-evaluation is a hands-on examination of the beneficiary and not just an update to the existing documentation and/or revision of a care plan that is performed once a therapy regimen is under way.

Example:
Therapist is evaluating goal achievement as part of the therapy session.

Therapy Supervision

- **Provided by licensed staff**
- **PTA and COTA under general supervision**
- **Therapy aides & Students require line of sight supervision**

Therapy Supervision

Licensed or certified professional therapists must provide or supervise the provision of the therapeutic service and coordinate the intervention with Nursing. Physical Therapy Assistants (PTA) and Certified Occupational Therapy Assistants (COTA) may provide therapy under the general supervision of the professional who must be accessible while they are providing the therapeutic service. As always, Medicare does not cover care provided by a Speech Language Pathology Assistant.

- All supervision must be provided by a licensed professional. PTAs and COTAs may not supervise any other personnel.
- A therapy aide or therapy student must be under the direct, personal supervision of the professional therapist “in a manner which allows for visual contact at all times.”

Therapy Minutes

- **Therapy received during the previous seven calendar days or since admission**
- **Therapy does not have to be on consecutive days**
- **RUGs represent minimum requirements**
- **Must be documented on daily attendance log**
- **A minute reflects actual treatment time**

Minutes of Therapy

A therapy minute reflects actual treatment received by the beneficiary, beginning with the first treatment activity or task and ending with the last procedure/apparatus completion.

The minutes of therapy received during the previous seven calendar days, or since admission, whichever is appropriate, are counted and reported on the MDS. The minutes of therapy, like any therapeutic intervention, must be supported by the medical record. For therapy services, key documentation will be in the MDS, therapy progress notes and therapy daily attendance log.

- RUG-III rehabilitation group minute thresholds are the **minimum** number of minutes required for classification into the group.
- No limits are to be placed on services provided to a beneficiary due to the facility's interpretations of minutes "allowed" by a particular RUG-III group.
- Therapeutic services performed by students are not counted unless provided under the direct, personal supervision of the licensed, professional therapist.
- Number of days and minutes of actual treatment received by the beneficiary (including set-up) during the 7 day 'look-back' period are counted and recorded in Section P of the MDS. No therapy minutes delivered prior to the SNF admission may be counted
- Treatment days and minutes need not be provided on all of the previous, consecutive days.

  Example:

  Beneficiary received physical therapy 50 minutes on 2nd and the 4th days of the stay.This will be recorded on the MDS Section P as 2 days and 100 minutes of PT.

- Minutes reported on the MDS are “actual time” and are not rounded to nearest 10 or 15 minute interval.

- PT, OT, ST provided outside the SNF may be counted and recorded on the MDS if provided by qualified staff. For example, transportation time to and from the beneficiary’s home before discharge is acceptable if the therapist accompanies the beneficiary and if the time in transport is utilized for education or discussion of the beneficiary’s treatment and or goals and for beneficiary/family conferences. (Per State Operations Manual, HCFA-Pub. 7, Transmittal #272 p. R64)

Group Therapy

- **4 or fewer beneficiaries**
- **May only equal 25% of weekly therapy**
- **25% applicable per discipline, e.g., ST**

Group Therapy

Group therapy is defined as a group of four or fewer participants working on the same activity. The group may be lead by a professional therapist or a PTA or COTA who is under the professional therapist's supervision. The total number of minutes spent is captured individually on each group member's MDS.

In addition, the following criteria apply:

- The time spent in group therapy only may equal 25% of the beneficiary's weekly therapy program time.
- The 25% limit is applied separately to each individual discipline: PT, OT, ST.
- The supervising therapist may not oversee/supervise any other therapy service provision while providing group therapy supervision.

MDS 2.0: Section T

Section T, items T1b, T1c, T1d, is the record of "ordered therapies." T1b asks "Has a physician ordered any of the following therapies to begin in the FIRST 14 days of the stay Pt, OT, or ST?" **If the answer is yes, the number of expected minutes and days is completed in items T1c and T1d**.
If the answer is no, then there is nothing reported in T1c or T1d.

If the physician order for therapy specifies 10 days, the minutes are captured over 10 days. In the absence of a specific time limit utilize 14 days, assuming the beneficiary continues to receive rehabilitative services.

RESPIRATORY THERAPY

The rules governing the provision of respiratory therapy treatment were not altered by PPS implementation and are described in the SNF manual, Section 230.10 C.

NOTICES OF NONCOVERAGE

A resident's acuity level may change so that the beneficiary is no longer in need of skilled care. In most such situations, no Significant Change in Status Assessment is required.

Once skilled care is no longer required, a Notice of Noncoverage must be issued, effective the following day. This is based on the custodial care exclusion from coverage and takes precedence over other Program provisions.

Notices of Noncoverage

- **Required when services are no longer skilled and/or reasonable and necessary**
- **Effective immediately**
- **Payment ends the following day**

Demand Bills

- **Required Review**
- **Prior 7/1/98 coverage determined by existing administrative criteria**
- **After 7/1/98 coverage determined by revised administrative criteria**
- **10/1/99 and after coverage is according to the FR**

DEMAND BILLS

A beneficiary has the right to request a demand bill for services that the SNF has determined to be noncovered, by indicating his or her wish to do so on the Notice of Noncoverage issued to them. (SNF Manual, Section 356.1)

- Prior to July 1, 1998, coverage is determined under the existing administrative criteria
- July 1, 1998 through Sept. 30, 1999 and upon facility entrance into PPS, coverage is determined according to the **revised** criteria in MIM-3, Section 3130-3132.
- Oct. 1, 1999 and after, coverage is determined according to the FR.

Detailed claim coding requirements may be found in the chapter on “Billing Principles for the FR”

MEDICAL REVIEW PROCESS UNDER PPS

Medical Review Coverage Criteria Per:

- **Program Integrity Manual**
- **MIM-3**
- **HIM**
- **Program Memoranda**

Medical review of SNF PPS claims will be done in accordance with the MIM-3, Program Integrity Manual, the HCFA Health Insurance Manual, and Program Memoranda.

Types of Medical Review:

- Pre-pay
- Random post-pay

  Random selection of the number of bills believed by the FI to be sufficient to ensure that providers are reporting correct information on the MDS and billing for covered SNF PPS services.
- Focused Medical Review

  FI's are to continue Focused Medical Review (FMR) according to MIM 3939.
- 100 percent of demand bills submitted must be reviewed by the FI MR department

FMR Bill Selection:

- In selecting their overall workload FIs may choose specific claims or target providers that historically bill at a higher volume, are known to be abusive, or are newly participating in Medicare.
- The target portion of review must not exceed 20 percent of the overall workload.

Medical Record Documentation Requirements

In response to an Additional Documentation Request (ADR) the following documentation is required:

- All applicable MDSs for the claim period billed
- All medical records for 30 days prior to each ARD applicable to this billing period, including but not limited to the following:
  - Hospital Discharge Summary
  - Admission Assessment
  - Care Plans
  - Progress Notes (Nursing, Rehabilitation)
  - Intake and Output Log
  - Vital Sign Log
  - Weight Records
  - Treatment and Medication Sheets and
  - Provider's written notice(s) of denial to the beneficiary and any reinstatement notices. Include dated verification that the beneficiary or representative received notification or documentation that telephone contact was attempted.

Medical Record Time Frame

- **30 Days prior to each ARD and the claim period billed**

Medical Record

Must Support the Following:

- **Level of care requirement**
- **Services documented on the MDS were delivered**
- **Services delivered were reasonable and necessary**

Requirements for Coverage

In order for a claim to be covered, the stay must meet all three criteria below:

- Level of care requirement as defined by the FR
- Services must not be statutorily excluded
- Services must be reasonable and necessary

Reminder:
It is important to remember that the medical record must support that:

- **Services documented on the MDS were actually delivered**
- **Services provided were reasonable and necessary for the relevant assessment period.**

Review of the 5-Day Presumptive Period

The services provided and received during the first days of the post-acute stay are **presumed** to meet the level of care requirements. However, the services upon which classification into one of the upper 26 RUG-III groups is based must be reasonable and necessary to diagnose or treat the beneficiary's condition.

Continued Coverage Decisions

Continued Medicare coverage for days after the initial post-acute period covered by the presumption is based on the continued need for, and receipt of, a skilled level of care. The reviewer will examine the record regarding the beneficiary's overall clinical status and care needs for the dates of service in review.

Medical Review Decisions

All medical review decisions are made on the basis of medical record documentation from the provider. The provider must demonstrate in it's documentation the medical necessity of the services provided.
There are four potential decisions listed below.

Medical Review Decisions

- **Based on provider documentation**
- **Must demonstrate medical necessity**

1. Services were documented and medically reasonable and necessary.

   The claim is approved for payment.

2. Rehabilitation RUG-III Groups

   - If rehabilitation is reasonable and necessary, but not at the level billed, the claim will be adjusted for the entire payment period according to a decision matrix (see Appendix "MR Decision Matrix")

   - If rehabilitation services are not reasonable and necessary, the reviewer will use the MR decision matrix to reclassify the beneficiary into one of the RUG-III clinical groups, if appropriate. If there are no criteria upon which to base classification into a clinical group, the claim will be denied.

   Provider is held liable in both cases

3. Insufficient documentation of services rendered

Claim is denied in full or part of the entire payment period

Provider is held liable

4. Lower 18 RUG-III groups

   - If the care provided was reasonable and necessary and met the SNF Level of Care requirements, then

     The claim is approved for payment

   - If the care was not reasonable and necessary or **did not meet** the SNF level of care requirements, then

     The claim is denied for the entire payment period

     Provider is held liable

Notices of Noncoverage

- **Issued on the date the medical record documentation no longer supports a skilled level of care or**
- **When the services rendered do not meet the medical necessity criteria**

NOTICES OF NONCOVERAGE

According to the final rule, when the documentation no longer supports the need for, or receipt of a skilled level of care, a decision of noncoverage is made by the reviewer and applied as of that date.

MEDICARE SUMMARY NOTICES (MSN)

The following chart represents the Beneficiary's message on the MSN, and the applicable provider ANSI Reason Code on the Remittance Advice

Insufficient Information Denial	**MSN 9.2** "The item/service was denied because information required to make payment was missing"	**ANSI B12** "Claim denied charges" and "Services not documented in patient's medical records"
Partial Payment at Reduced Rate (Matrix)	**MSN 15.8** formation provided does port the level of service vn on the claim."	**ANSI 57** denied charges" and "the claim/service denied/reduced because the 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	**MSN 13.3 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 50** "Claim charges denied" and "These are non-covered services because this is not deemed a medical necessity by the payor."
Demand Bill Agrees With Provider's Determination of Noncoverage	**MSN 16.42** "The provider's determination of non-coverage is correct."	**ANSI 50** "These are non-covered 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 not 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 copy of this notice, your provider's bill, a receipt or proof that you have paid the bill."	**ANSI 116** "Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements."
Improper Placement in a Noncertified Bed	**MSN 13.7** "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**."**
Billing Error	**MSN 9.4** "This item or service was denied because information required to make payment was incorrect."	**ANSI A1** "Claim Denied Charges"

MEDICAL REVIEW DECISION MATRIX

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 clearly matched the billed ADLs. Services billed in the Medium Rehabilitation category were reduced to Low Rehabilitation.

MATRIX B

RUG Category Billed:	Adjust To:				
	Extensive Services	**Special Care**	**Clinically Complex**	**Lower 18**	**Not R and N and NO Qualifying Clinical Condition**
Rehabilitation RUC,RVC,RHC,RMC,RBL	SE1	SSC	CC1	PA1	DENY
Rehabilitation RUB,RVB,RHB,RMB	SE1	SSA	CB1	PA1	DENY
Rehabilitation RUA,RVA,RHA,RMA,RLA	X	SSA	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 CCE,CC1,CB2,CB1CA2, CA1	X	X	X	PA1	DENY
ALL LOWER 18 RUG-III GROUPS	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 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 the category was selected. In some cases, the adjusted RUG code may fall into a different category than was selected when using the MDS 2.0 RUG-III Codes.

MEDICARE ASSESSMENT SCHEDULE

DAY 1= Admission or Re-Admission

Medicare Assessment Schedule	**Assessment Reference Date Including Grace Days**	**Reason For Assessment *#AA8b MDS 2.0 Users Guide***	**Applicable Medicare Payment Days**
DAY 5* FULL**	Days 1-8	1 Medicare 5-Day Assessment	1-14
DAY 14 FULL	Days 11-19	7 Medicare 14-Day	15-30
DAY 30 Full	Days 21-34	2 Medicare 30-Day	31-60
DAY 60 Full	Days 50-64	3 Medicare 60-Day	61-90
DAY 90 Full	Days 80-94	4 Medicare 90-Day	91-100

***If a resident expires or transfers to another facility before day 8 an MDS is prepared as completely as possible allowing for RUG classification and Medicare payment purposes.**

**** Full Assessment = Entire MDS, including Section T**

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 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 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) and/or (K6b = 2,3,4,or 5)	 17-18 15-16 7-14	 NOT USED NOT USED NOT USED	 SSC SSB SSA
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, inappropriate behavior or resists care; or hallucinations, or delusions checked	6-10 6-10 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving	BB2 BB1 BA2 BA1
PHYSICAL FUNCTION REDUCED	16-18 16-18	Nursing Rehabilitation*	PE2 PE1

CATEGORY	ADL INDEX	END SPLITS	MDS RUG III CODES
No clinical conditions used	11-15 11-15 9-10 9-10 6-8 6-8 4-5 4-5	not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving	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 Users 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

CHAPTER 2: BILLING

BILLING PRINCIPLES PER FINAL RULE

Billing guidelines for SNF PPS modify the existing rules in the SNF manual (HCFA PUB. 12), Section 500 – 600, to meet requirements of the Balanced Budget Act of 1997. The Final Rule (FR) which was published on July 30, 1999, clarified the coverage and billing criteria for SNF PPS.

Payment and Billing Changes Per FR

Financial and billing changes per final rule

- New PRICER effective 10/1/99
  - federal rates modified
  - wage indexes modified

- Recalculate Payment Sheets
  - ALL SNFs should recalculate payment masters for reimbursement for dates of service 10/1/99 – 12/31/99
  - Use current provider specific rate, with new federal rates

- New fee schedule for therapy services 01/01/00

- BBRA (11/99) provided a Part B “add on” for demo facilities

- New blend year begins with new cost report year on or after 7/1/99

- New facility specific rate issued at the start of each new cost report year during the PPS transition

- **No** major changes in the billing instructions per the FR, but several clarifications were made for the billing of demand bills, MSP, Leave of Absence, HMO, and Hospice claims

Claim Coding Requirements That Remain Unchanged by the Final Rule

Traditional claim coding requirements unchanged by PPS

- HCFA 1450 claims are submitted to the FI on a 30-day schedule (monthly billing)
- Part A claims must be submitted in sequential order per each admission date **including no-pay discharge claims**
- Maximum number of covered Part A SNF days in a benefit period is 100
- Field assignments on HCFA 1450 have not been modified in length
- HCPCS are **not** required on Part A claims for ancillary services
- When a beneficiary is no longer covered by Part A benefits in the SNF, Part B claims may be submitted to FI for ancillary services per SNF manual (HCFA PUB. 12), Section 260

PPS Required Billing Codes

SNF PPS coding requirements

- **Revenue Code 0022** for each assessment affecting the billing period
- **HIPPS** (health insurance prospective payment rate) code in field locator (FL) 44
- **Assessment Reference Date (ARD)** of the MDS in FL 45
- **Number of Covered Days (Units)** in FL 46 for each HIPPS code billed
- **Accommodation information** (revenue code + rate x days =charges)

FACTORS WHICH AFFECT THE BILLING OF SNF PPS CLAIMS

Relationship Between the Assessment and the Claim

SNF PPS establishes a schedule of Medicare assessments. The schedule is followed throughout a beneficiary's stay and is interrupted only by discharge, a change in level of care or the end of technical eligibility. The Medicare assessment chart indicates the maximum number of days that can be billed per each assessment.

Timing of the Assessments

When to begin a Medicare assessment schedule

An assessment schedule for each eligible Medicare resident begins:

- On admission
- On readmission
- On **day one of Medicare coverage** (following an MSP period, following a **"cut"** period of less than 30 days, or following a physician's **hold** period due to medical predictability)

ASSESSMENT REFERENCE DATES (ARD)

- The ARD is the **end of the observation period** for scoring clinical information on the MDS 2.0. The date is set by the clinical staff and entered on line A3 of the MDS.

- The ARD must be accurately conveyed to the billing staff in order to correctly complete a UB-92 for the service period.

Reporting the Assessment Reference Date (ARD) on the Claim

ARD and the claim

- Each assessment **must** have an ARD (if no assessment was completed, bill the claim with the default code if covered care was provided)
- The **ARD** reported on the claim in FL 45 **must match** the date on the MDS document SECTION **A3**
  - If it does **not** match, the FI may return the claim to the provider (on prepay demand bills) or cancel payment (on a post pay review).
  - Failure to code this date correctly results in an improperly billed claim and **no** Medicare payment may be made.
  - ARD is **required** on all HIPPS lines **except** when billing the default code (AAA00).

The Regular Assessment Schedule and Billable Days for Resident with Full Benefits in an Uninterrupted Stay

Regular Medicare assessment schedule

- Day 5 assessment provides a billing code for day 1 – 14
- Day 14 assessment provides a billing code for day 15 – 30
- Day 30 assessment provides a billing code for day 31 – 60
- Day 60 assessment provides a billing code for day 61 – 90
- Day 90 assessment provides a billing code for day 91 – 100

See Assessment Schedule Table

PAYMENT SCHEDULE

Correct Coding of Claims Based on Payment Schedule

Billing the payment blocks

- Bill for **entire block** of payment period **unless**:

– benefits exhaust
– patient discharges/dies/transfers
– there is a change in level of care to
– non-skilled
– there is a change in medical condition requiring an Other Medicare Required Assessment (OMRA) or Significant Change in Status Assessment (SCSA)

- Split bills based on calendar month, not on payment blocks

- Change HIPPS codes for each regular assessment at the beginning of the payment block , unless it is an OMRA or SCSA – these HIPPS codes **change with the ARD** of that special assessment (unless the ARD is in the "grace day" period)

- Remember to "restart" the assessment schedule for readmits and for beneficiaries who return to skilled care following a "cut"

– use the proper modifier to reflect which assessment is being billed

– when the schedule starts over, the benefit period does not start anew, unless there has been a break in spell of illness

MODIFIERS

Nineteen (19) valid modifiers define the type of Medicare assessment completed (see chart). Modifiers must accurately reflect which assessment is being used to bill the RUG group for Medicare reimbursement. The modifier will validate the **type of assessment** and the **length of time (days) allowed for payment** under SNF PPS for that assessment.

Modifiers – the right information for the claim

Correct Claim Coding Using Modifiers

- Clinical staff must determine the modifier and pass this information to the billing staff.
- Any incorrectly assigned modifier can result in an incorrectly billed claim.

– Incorrectly billed claims will either be RTP'd (on prepay demand bill review) or payment canceled (on postpay medical review).

– Future edits will RTP claims with incorrect modifiers.

- Modifiers (selected from allowed listing) must match the reason for Medicare assessment in AA8b of MDS even though the modifier is not chosen from that MDS section.

– **Do not add AA8a + AA8b** (from MDS) together to get modifier code.

– **Do** take the **reason for assessment in AA8b** and select the proper code for the claim from the Medicare list of approved modifiers.

5-DAY PRESUMPTION OF COVERAGE

Billing for " Presumption of Coverage" at Day 5 Assessment

- FR establishes "presumption of coverage" through the **ARD** of the 5-day assessment
- The clinical staff must make the coverage decision by the 5-day **ARD**
- Clinical staff will determine if notice of non-coverage if necessary

Billing under presumption of coverage on the 5-day assessment

- **Provide the billing department** with the HIPPS code and dates of service that may be billed to Medicare
- If SNF resident is **no longer receiving skilled care** by ARD of day 5 assessment, Medicare can only be billed from admit date through ARD. Beneficiary would then be "cut" from coverage

– Code claim with Occurrence Code 22 = to the ARD

Example 1: Patient admitted on 11/1/99

- ARD set for 11/6
- RUG code from assessment = CC1
- Per clinical perspective, resident is **no** longer receiving skilled services on ARD
- Bill 6 covered days (11/1 – 11/6)
- Occurrence Code 22 = 11/6

Example 2: Patient admitted on 11/1/99

- ARD set for 11/6
- RUG code from assessment = CC1
- Per clinical perspective, resident **is** receiving daily skilled services Bill 14 covered days (11/1 – 11/14)

Claim Example 1

DEMAND BILLS

Demand bills must be sent to the FI any time the beneficiary requests the SNF to do so. The beneficiary makes this request by marking the box on the notice of non-coverage that requires a claim to be billed. Demand bills must be submitted even in cases of technical ineligibility. The FI will handle those cases differently because no medical review is necessary when the patient is not technically eligible for Part A reimbursement.

Coding for demand bills

Claim Coding for Demand Bills

- There must be a valid HIPPS code on the claim (use default code AAA00 only in the absence of a valid MDS).

- For SNF residents that have Part A days available to use, there must be a separate HIPPS code on the claim for each block of time that would have been represented by a new Medicare required assessment.

– For a technically ineligible beneficiary (no qualifying hospital stay, benefits exhaust, etc.) you may use the default code AAA00.

Use default code ONLY when NO MDS was completed

- The minimum requirement is to bill from the from the first non-covered day to the end of the billing period.

- Medical review will be pre-pay for beneficiaries who have Part A days to use (see clinical chapter for documentation requirements).

- Do **not** attach medical information to the paper claim or enter clinical information on page 7 of the electronic.

- Submit the claim with non-covered days, non-covered charges, and HIPPS code line units = 0.

What next?
Billing when FI upholds SNF decision of non-coverage

Demand Bills Following MR Review to Uphold SNF Decision of Non-coverage

- Beneficiary Liability Assigned

– Beneficiary must make payment for continued stay even if appeal is filed

– Subsequent requests for demand bills must be sent and SNF should notify FI if the patient is now technically ineligible due to 30 days of non-coverage (use remarks screen)

– If non-coverage on previous demand bill is less than 30 days, the subsequent demand bill must be reviewed according to normal procedure for technically qualified resident

- Provider Liability Assigned

– Decision may be appealed

– Provider may **not** bill the resident for dates of provider liability

What next?
Billing when FI overturns SNF decision of non-coverage and pays the claim

Demand Bills Following MR Review to Overturn and Pay SNF for Covered Care on a Demand Bill

- Submit subsequent claims **non-covered** following all the billing requirements (HIPPS Codes, ARD, etc.).
- For technically eligible residents (with benefit days available), SNF may **not** bill the resident until the medical review decision is made.

Claims example 2

Claims Example 3

LATE OR MISSED ASSESSMENTS

SNF PPS allows for a window of time in which the assessment is started and completed. The regulation includes the possibility of adding extra days (late days) for the completion of each MDS 2.0 without a penalty.

Late days allowed for completing the assessments

- **Use of default HIPPS code**

- Billing the default code signifies that the SNF considers the resident to be at a **skilled level of care**, but no assessment was completed to classify him/her into a RUG III group

Billing Claims For Late Assessments

- Default code **must** be used in all cases when the ARD of the required assessment was not set timely
- Default code is applied for **all** days until the ARD is set for the late assessment
- HIPPS code from late assessment becomes effective with ARD
- HIPPS code is valid until the next regularly scheduled assessment
- Late assessments **never** replace the next regularly scheduled assessment

Example

– Patient admitted 12/1/99
– ARD for 14 day should be set between 12/11 – 12/19
– ARD set on 12/23
– bill default (AAA00) 12/15 – 12/22
– bill HIPPS code from late assessment for days 12/23 – 12/30
– modifier is 07 (modifier is always for the assessment which is currently due)

30-day assessment is due on schedule

claims example 4

SPECIALITY CLAIMS BILLING

Residents Who Are Not Affected by SNF PPS Schedule

PPS regulations do not apply to all Medicare beneficiaries in a SNF. When it is determined that the beneficiary's care is reimbursed under a different payment source, the PPS assessment schedule need not be followed.

Medicare Beneficiaries Enrolled In HMOs

SNF PPS affect on HMO beneficiaries

- **Risk HMOs**
- **Cost HMOs**

A Medicare beneficiary in a risk HMO (Option C) will be covered (or not) based on the policies of the insurer; however, the HMO may never offer the beneficiary anything less than what is provided to the fee-for-service beneficiary

- Bill the HMO according to contract terms
- Assessment schedule does not need to be followed for Medicare billing purposes
- HCFA 1450 must be submitted to the FI for benefit management (the default code AAA00 may be used)
- Residents receiving HMO denials must file an appeal with the HMO. Do not send a demand bill to the FI.

A Medicare beneficiary in a Cost HMO (Option 1) has a choice of where to receive services. All claims for Cost HMO beneficiaries in a Medicare certified SNF are sent to the FI for processing

- Follow the SNF PPS assessment schedule
- Submit a HCFA-1450 to the FI using the HIPPS rate code for each required Medicare assessment

claims example 5

SNF PPS effect on hospice beneficiaries

- **Hospice beneficiaries admitted to SNF for their terminal Illness**
- **Hospice beneficiaries admitted to SNF for a non-hospice related illness**

Medicare Beneficiaries Who Are In Hospice

Medicare beneficiaries enrolled in the hospice program who are admitted to the SNF for their terminal illness are not covered by inpatient Part A SNF benefit.

- Do not follow the PPS assessment schedule
- No discharge claim is necessary
- Be alert for beneficiaries who opt out of the hospice program and revert to traditional Medicare coverage

Medicare beneficiaries enrolled in hospice who are admitted to a SNF for a condition unrelated to their terminal illness **are** governed by PPS regulations.

- Follow the PPS assessment schedule
- Bill covered claims with valid HIPPS codes
  - Condition Code 07 must be present on the claim

claims example 6

Beneficiaries With Other Insurance Coverage

Medicare regulations require SNFs to follow admission practices, which include a survey for coverage by another insurer. If another insurance company is responsible for the payment of the SNF stay, the SNF will bill that insurer according to the rules of the insurance company. Medicare Secondary Payer (MSP) rules will affect the use of the SNF PPS assessment schedule and use of RUG III codes.

Affect of other insurance on SNF PPS assessment schedule

- **MSP categories**
- **Beginning an assessment schedule when other insurance ends or denies**
- **Submission of MSP claims**

Eight Categories of MSP Coverage

- Working Aged
- ESRD
- Auto/No Fault
- Liability
- Workers Compensation
- Disability
- Federal Black Lung
- VA Benefits

When Assessments are Done

- When a specific time period is guaranteed by another insurer (usually by an employer group health plan) , the assessment schedule begins when the primary insurer's coverage ends.
- When the other insurer is indefinite in the amount of days to be paid, it is recommend that you follow the assessment schedule from day of admission.

Billing Claims During a MSP Period

- All Part A MSP claims must be submitted to the FI to satisfy the sequential claims processing requirements prior to billing Medicare days
    - Bill claims with covered days and charges
    - Use condition code 77 if payment is accepted as 'payment in full'
    - SNF PPS coding must be present on the claim including HIPPS codes and ARD
    - Default code AAA00 may be used if no Medicare Secondary payment is sought
    - All applicable MSP billing requirements must be met

Coding for MSP claims

Billing Claims after Other Insurance Ends

- Part A Medicare primary claims follow the MSP period if the beneficiary continues to meet skilled level of care criteria
- Begin the MDS schedule on first day that Medicare becomes primary
  – First day of Medicare coverage is day one of the Medicare schedule
  – First assessment would use 01 modifier for Medicare billing (5-day assessment)
  – Use the modifier 01 (5 day) regardless of where the patient was in the schedule, and bill for all of the days until the next assessment is scheduled
- If primary insurance file is still "open," code your claim with occurrence code 24: date other insurance company denied payment

When to begin a Medicare assessment schedule

claims example 7

claims example 8

claims example 9

Leave of absence

Leave of Absence (LOA) Rules

Leave of absence criteria have not changed for SNF PPS. Any time a resident does not meet midnight census taking, he is considered to be on a leave of absence. There are two types of LOA situations:

- Medical LOA – resident is in emergency room of hospital but has not been admitted as an inpatient

– Absences exceeding 24 hours constitute a "discharge" for the purposes of consolidated billing

- Therapeutic (Social) LOA – resident has gone home with family

Coding Requirements for Leave of Absence

- Occurrence Span Code 74 and dates
- Revenue code 018X in FL 42
- Number of days on LOA in FL 46
- 0 (zero) charges in FL 47

Effect of LOA on Benefit Days and Assessment Schedule

- Medicare Part A benefit days are not taken

- Do not code non-covered charges on LOA days

- LOA days do not interrupt the assessment schedule and are not counted on the MDS when scoring the patient's next assessment

Outside services rendered to the SNF patient on a LOA day are not bundled to the SNF, but may be billed directly to Medicare by the entity performing the service.

claims example 10

NEW SPELL OF ILLNESS

There is no limit to the number of benefit periods a beneficiary may have as long as he/she meets the criteria for ending a current spell of illness.

Criteria For Breaking The Current Spell of Illness

- 60 consecutive days facility free
- 60 consecutive days in a SNF at a non-skilled level of care

Spell of illness

- **Criteria for breaking current spell of illness**
- **Use of occ. code 22**
- **Use of occ. code A3**
- **Discharge bills**

CODING FOR CONTINUING STAY RESIDENTS

- Prior to benefits being exhausted, occurrence code 22 is coded on the claim as the last medically skilled day
- This is a covered day on the claim
- This is the same day as the date of the notice of non-coverage

– Days following occurrence code 22 are non-covered and should be submitted on a separate claim if the resident asks for a demand bill

- Benefits exhaust code (A3) does not impact benefit periods – it does not break spells

– Occurrence code 22 and A3 should not appear on the same claim

Effect of Discharge Bills on Benefit Periods

Medicare regulations outlined in Section 517 of the HCFA PUB 12 describe the requirement for all SNFs to track the days beneficiaries live in a SNF.

Discharge bills

- SNFs **must** submit a discharge bill for all residents who are enrolled in Part A (unless that resident is being covered by the Hospice)
- Discharge claims should be submitted at the time of transfer, death, discharge to home or another facility
- Claims should close a sequence (TOB 214) or **may** be submitted as a TOB 210
- A single discharge claim is all that is required (unless you are crossing the start date of PPS) from the first day of non-coverage until the date of discharge

– Apply occurrence code 22 and date to the discharge claim if a change to non-skilled level of care has occurred since the last covered day

– Do **not** apply occurrence code 22 to the discharge claim if the beneficiary has remained skilled

- Facilities may also bill a single claim through change of level of care or a move to a non-certified bed

– Claims billed in this manner **must** have occurrence code 22 and date = to the “through date” of the claim

Failure to submit discharge bills creates an artificial gap in service on CWF and establishes a new benefit periods inappropriately.

Intentional failure to submit discharge bills for the purpose of creating a new benefit period is fraud.

CODING

Billing Requirements for HCPCS/Rate (FL 44)

- When billing for accommodations, code your customary charge in the FL 44.
- When billing revenue code 0022, code the HIPPS rate code in FL 44.
- Part A claims do **not** require HCPCS codes for ancillary services.

SNF PPS field requirements

- **HCPCS**
- **Service date**
- **Units**
- **Total charges**

Billing Requirements For Service Date (FL 45)

- Required field on revenue code 0022 line for reporting ARD
- No other revenue line requires a service date on a Part A claim

Billing Requirements for Units (FL 46)

- When billing accommodations, units are days.
- When billing HIPPS codes, units represent days covered by a specific assessment.
- When billing therapy ancillary services, units represent number of times therapy procedures were performed.
- When there is no specific time frame to be reported, the number 1 must be coded in the units field.

Billing Requirements for Charges (FL 47)

- Required on all revenue code lines except 0022 (PPS code) and 0180 (LOA)

THERAPY EDITS

Edits For Therapy Ancillary Charges

Therapy Ancillary Edits

- **Required if billing any of the RUG III rehab groups**
- **Ultra high rehab groups require 2 therapy ancillary revenue codes on claim**
- **All other rehab groups require 1 therapy ancillary on claim**

SNF PPS requires the billing of ancillary charges for residents who score in a RUG III rehab group.

System edits have been developed to insure that the rehab RUG III groups are not billed unless therapy ancillaries appear on the claim.

- Residents in the highest rehab groups (RUA, RUB and RUC) require ancillary revenue codes for two therapy disciplines
- Residents in the lower rehab groups (RLA–RVC) require ancillary revenue codes for one therapy discipline
- Claims that fail system edits will be returned to provider for corrected submission

Therapy Processing Problems

Medicare does not require an OMRA be done **unless** all therapy has ended. When a resident in an ultra-high therapy RUG III Group decreases therapy, there is no mechanism to obtain a new HIPPS code for continued billing. SNFs are permitted to code the existing HIPPS code from the last assessment until the next assessment is due.

Continued billing of an ultra-high rehabilitation HIPPS code without two therapy ancillaries to support the group will fail system edits.

Workaround for Therapy Edit Problem

EDIT PROBLEM

Therapy workaround

- Enter a single line of coding to represent the therapy which has been discontinued
  - 429 for discontinued PT
  - 439 for discontinued OT
  - 449 for discontinued ST
- Enter a unit of 1
- Enter charges of .01

REIMBURSEMENT UNDER SNF PPS

Medicare Part A claims will be run through a PRICER software program provided to the FI by HCFA. The software contains the reimbursement amounts (rates) for each RUG III group. In combination with the rate information from each individual provider file, the FI's computer will be able to calculate payment for each claim regardless of the number of different RUG III codes present.

Changes in reimbursement rates

Changes to Reimbursement Rates Under SNF PPS

- Provider Specific rates are assigned at the beginning of each new cost reporting period
- Federal Rates change on 10/1 of each year and affect all SNFs who receive blended payment
- Blend ratios during the three year transition to PPS change at the beginning of each SNF's individual cost report year
- Final Settlement may result in a change to provider specific rate or the Part B rate

– Audit and Reimbursement department sends a new rate sheet **each** time a facility has a change in payment

Reimbursement

- **Separate calculation for each HIPPS code entered on a claim**
- **Beneficiary co-insurance remains as is currently calculated**
- **Payment = total of each HIPPS payment minus beneficiary co-insurance responsibility**
- **Payment for ancillary services on claim is factored into HIPPS reimbursement**

Withholding

Reimbursement Data on Part A Claim

The RUG III reimbursement rate will overlay the zero charge in FL 47 for each line of data submitted with a revenue code 0022 and a HIPPS rate code

- The total charges field will **not** be altered on any other line of data and total charges will go to the PS&R report as submitted by provider.
- Each RUG III group on the claim will be calculated separately, then totaled to determine reimbursement.
- Beneficiary co-insurance responsibility is calculated and subtracted from total reimbursement to establish the payment amount.

Withholding Issues

The Medicare FI may create a withholding (of payment) for SNFs in the following circumstances:

- Failure to file cost report by required deadline
  - 100% withholding remains in place until cost report is submitted and accepted
- Overpayment on final settlement
  - 100% unless payment arrangements are made on amount of overpayment or if payment arrangements are not met
- Credit balance
- Adjustments
  - Withholding resulting from claims processing occurs when an adjustment cancels original claim pending the reprocessing of the corrected claim
  - When the adjusted claim is finalized, the correct payment is restored

THE ADJUSTMENT PROCESS UNDER PPS

Adjustments

The claim adjustment process has not been changed for SNF PPS. Follow your normal procedures to adjust any claim in which data elements need to be corrected.

Provider Adjustments

- Adjustment claims are submitted with type of bill 217
- Condition code (D0 – E0) in FL 24 must be coded to provide reason for adjustment
- **Remarks** are required when using D8 and D9 as reasons for adjustments
- Provide cross reference DCN of original claim
- All adjustments to the MDS document must follow the MDS instruction manual

Intermediary Adjustments

- Alerts from Common Working File (CWF) regarding a change in benefit days may result in a full or partial adjustment
- PRO review may result in their request for our office to do adjustments
- Adjustments to facilitate Appeal decisions
- Adjustments to RUG category following Medical Review decision
- Mass adjustments following a policy or reimbursement change