Medicare Program Integrity Manual
Chapter 6 - Intermediary MR Guidelines for Specific Services

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(Rev. 475, 07-19-13)

Transmittals for Chapter 6

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

(Rev. 196, Issued: 03-30-07, Effective: 01-01-06, Implementation: 04-30-07)

Effective with cost reporting periods beginning on or after July 1, 1998, Medicare began paying skilled nursing facilities (SNFs) under a Prospective Payment System (PPS). PPS payments are per diem rates based on the patient's condition as determined by classification into a specific Resource Utilization Group (RUG). This classification is done by the use of a clinical assessment tool, the Minimum Data Set (MDS) and is required to be performed periodically according to an established schedule for purposes of Medicare payment. Each MDS represents the patient's clinical status based on an assessment reference date and established look back periods for the covered days associated with that MDS. Medicare expects to pay at the rate based on the most recent clinical assessment (i.e., MDS), for all covered days associated with that MDS. This means that the level of payment for each day of the SNF stay may not match exactly the level of services provided. Accordingly, the medical review process for SNF PPS bills must be consistent with the new payment process. The methodology for medical review of SNFs has changed under the prospective payment system from a review of individualized services to a review of the beneficiary's clinical condition. Medical review decisions are based on documentation provided to support medical necessity of services recorded on the MDS for the claim period billed.

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

All contractors are to review, when indicated, Medicare SNF PPS bills, except for the excluded services identified in §4432(a) of the BBA and regular updates which can be accessed by contractors at: http://www.cms.hhs.gov/SNFConsolidatedBilling/01_Overview.asp#TopOfPage . The goal of medical review is to determine whether the services are reasonable and necessary, delivered in the appropriate setting, and coded correctly, based on appropriate documentation. Under PPS, beneficiaries must continue to meet the regular eligibility requirements for a SNF stay as described in CMS IOM Pub. 100-02, chapter 8, §20, such as the 3-day medically necessary hospital stay and admission to a participating SNF within a specified time period (generally 30 days) after discharge from the hospital.

Under PPS the beneficiary must continue to meet level of care requirements as defined in 42 CFR 409.31. CMS has established a policy that, when the initial Medicare required 5-day assessment results in a beneficiary being correctly assigned to one of the upper 35 RUG groups, this effectively creates a presumption of coverage for the period from the

first day of the Medicare covered services up to, and including, the 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. See CMS Pub IOM 100-02, Chapter 8, §30.1 for further explanation of the administrative presumption of coverage.

In the case described above, where the administrative presumption of coverage exists, contractors shall review the bill and supporting medical information to determine whether the beneficiary did indeed meet the SNF level of care requirement for all days subsequent to the assessment reference date of the Medicare required 5-day assessment. In the case where the beneficiary is correctly classified into one of the lower 18 RUG categories, the contractor shall review the bill and supporting medical information to determine whether the beneficiary met the SNF level of care requirement from the beginning of the stay. If the beneficiary met the level of care requirement, contractors shall also determine whether the furnished services and intensity of those services, as defined by the billed RUG group, were reasonable and necessary for the beneficiary's condition. To determine if the beneficiary was correctly assigned to a RUG group, contractors shall verify that the billed RUG group is supported by the associated provider documentation. Contractors shall consider all available information in determining coverage. This includes the MDS, the medical records including physician, nursing, and therapy documentation, and the beneficiary's billing history.

6.1.1 - Types of SNF PPS Review

(Rev. 196, Issued: 03-30-07, Effective: 01-01-06, Implementation: 04-30-07)

Contractors shall no longer perform random postpayment reviews specific to SNFPPS bills. Instead, SNFPPS MR should be conducted on a targeted prepayment or postpayment basis. Consider the principles of Progressive Corrective Action (PCA) when conducting MR (See CMS Pub IOM 100-08, chapter 3, §3.11 for information on PCA). Contractors are also required to continue to review 100% of SNF demand bills, from beneficiaries entitled to the SNF benefit. (See B below.)

A. Data Analysis and Targeted (Focused) Medical Review

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

- Data Analysis—Conduct data analysis to identify normal practice patterns, aberrancies, potential areas of overutilization, and patterns of non-covered care. Data analysis is the foundation for targeting medical review of claims. As described in CMS PUB IOM 100-08, chapter 2, §2.2, data should be collected and analyzed from a variety of sources, including but not limited to SNF PPS billing information, data from other Federal sources (QIOs, 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 claims where there is the greatest risk of inappropriate program payment.

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

Contractors shall continue to track and report edit effectiveness through the standard activity reports.

B. Demand Bills

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

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

Demand bills are bills submitted by the SNF at the beneficiary's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and requests that the bill be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. The SNF must have the proper liability notice consistent with Section 1879 of the Social Security Act signed by the beneficiary unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative, or other authorized representative may make the request (See 42 CFR 424.36, Signature requirements). In the case where all covered services are being terminated, the SNF provider is also required to have issued an expedited determinations notice, as detailed in 2005 CMS Transmittal 594 and on the CMS website at www.cms.hhs.gov/BNI/ (see "FFS ED").

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

The HIPPS code and revenue code 0022 must be present on the demand bill. There may be cases where the contractor receives a demand bill for which no associated MDS (or other required Medicare assessment) was transmitted to the state repository because the provider did not feel that the services were appropriate for Medicare payment. In these cases, if the contractor determines that coverage criteria are met (see § 6.1.3 B.), and

medically necessary skilled services were provided, the contractor shall pay the claim at the default rate for the period of covered care for which there is no associated MDS in the repository. If the 14-day State assessment has an assessment reference date within the assessment window of either the Medicare 5-day or 14-day assessments, it may be used as a basis for billing the days associated with one of those Medicare-required assessments.

C. Bills Submitted for Medicare Denial Notices

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

6.1.2 - Bill Review Requirements

(Rev. 196, Issued: 03-30-07, Effective: 01-01-06, Implementation: 04-30-07)

Contractors must conduct review of SNF PPS bills in accordance with these instructions and all applicable PIM sections, including but not limited to, FI standard operating procedures for soliciting additional documentation, time limitations for receipt of the solicited documentation, claim adjudication, and recoupment of overpayment. Minimum requirements of a valid SNF PPS bill are:

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

A Health Insurance Prospective Payment System (HIPPS) code must also be on the bill. This is a five-character code. The first three characters are an alpha/numeric code identifying the RUG classification. The last two characters are numeric indicators of the reason for the MDS assessment. See CMS Pub. IOM 100-02, chapter 6, §30.1 for valid RUG codes and assessment indicators.

6.1.3 - Bill Review Process

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Note that these instructions DO NOT apply to the review of SNF swing-bed claims. Further instruction on review and adjustment of swing bed claims will be forthcoming.

A. Obtain Records

Contractors shall obtain documentation necessary to make a MR determination. Medical records must be requested from the provider and the MDS data must be obtained from the national repository. Contractors are to use the MDS as part of the medical documentation used to determine whether the HIPPS codes billed were accurate and appropriate. For

claims with dates of service beginning January 1, 2006, contractors must use the MDS extract tool to obtain the MDS from the state repository for each billing period reviewed. Additional information about the use of the FI extract tool can be found in the User's Guide. The tool and guide can be found at http://c1r5u03-web.sdps.org/qiesextract/. Once the clinical reviewer has utilized the FI Extract Tool to obtain the MDS(es) corresponding to the period being reviewed, the reviewer will import the MDS data into the MDS QC Software System to convert it into a readable format to be used, in conjunction with review of the medical record, for the adjustment of the SNF claim. The MDS QC System Software and Reference Manual can be downloaded at http://www.fu.com/fitools/.

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

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

During the review process, if the provider fails to respond to a contractor's Additional Documentation Request (ADR) within the prescribed time frame, the contractor shall deny the claim. See CMS Pub IOM 100-08, chapter 3, section 3.4.1.2 for information on denials based on non-response to ADRs and 3.4.1.4 for handling of late documentation. If the provider furnishes documentation that is incomplete/insufficient to support medical necessity, adjust the bill in accordance with §1862(a)(1)(A) of the Act.

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

B. Make a Coverage Determination

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

- **MDS must have been transmitted to the State repository —** The contractor shall require that the provider submit the claim with the RUG code obtained from the "Grouper" software, as instructed in CMS Pub IOM 100-04, chapter 6, § 30.1. Claims for which MDSes have not been transmitted to the state repository should therefore not be submitted to Medicare for payment, and shall be denied. An exception to that instruction occurs in the case where the beneficiary is discharged or dies on or before day 8 of the SNF admission or readmission, as described in the Provider Reimbursement Manual, chapter 28, §2833 F. In that specific case, contractors shall pay claims at the default rate, provided that level of care criteria were met and skilled services were provided and were reasonable and necessary. In all other cases, the contractor shall deny any claim for which the associated MDS is not in the national repository. The contractor shall issue these denials with reason code 16, remark code N29, and shall afford appeal rights.

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

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

  - Under PPS, the beneficiary must meet level of care requirements as defined in 42 CFR §409.31. CMS has established a policy that, when the initial Medicare required 5-day assessment results in a beneficiary being correctly assigned to one of the upper 35 RUG groups, this 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. See Pub IOM 100-02, chapter 8, §30.1 for further explanation of the administrative presumption of coverage.

  - Administrative presumption of coverage DOES NOT exist for a beneficiary who is correctly assigned into one of the lower 18 RUG groups on the initial 5-day assessment, so documentation must support that these beneficiaries meet the level of care requirements.

  - For all assessments, other than the initial 5-day assessment, determination of the continued need for, and receipt of, a skilled level of care will be based on the beneficiary's clinical status and skilled care needs for the dates of service under review.

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

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

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

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

If the reviewer determines that some of the services were not reasonable and necessary, follow the instructions in the following subsection to utilize the MDS QC Software System Software, version FI-5.01 to calculate the appropriate RUG code and pay the claim according to the calculated code for all covered days associated with the MDS.

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

If the reviewer determines that coverage criteria are met and services are not statutorily excluded, but some services provided were not reasonable and necessary or were not supported in the medical record as having been provided as billed, the MDS QC System software, version FI-5.01 must be used to calculate appropriate payment. Contractors shall pay claims according to the RUG value calculated using the MDS QC tool, regardless of whether it is higher or lower than the RUG billed by the provider. If none of the services provided were reasonable and necessary, the contractor shall deny the claim in full.

Contractors shall use the MDS QC System Software, version FI-5.01 to review and calculate appropriate payment for SNF claims with dates of service prior to January 1, 2006, which fall into the older, 44-group RUG classification system as well as for those with dates of service on or after January 1, 2006, which fall into the newer, 53-group RUG classification system.

The medical reviewer will examine the medical documentation to make a determination as to whether it supports the data entered into the MDS assessment completed by the provider and extracted from the state repository. If a discrepancy is noted, the reviewer shall enter the correct data reflected in the medical record, according to the instructions in

the MDS QC System Software reference manual. The reviewer shall consider all available medical record documentation in entering data into the software. This includes physician, nursing, and therapy documentation, and the beneficiary's billing history. Review of the claim form alone does not provide sufficient information to make an accurate payment determination.

D. Outcome of Medical Record Review

Once the contractor has:

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

2. determined whether coverage criteria are met; and

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

4. entered correct data into the MDS QC tool when discrepancies were noted, the contractor shall take action to pay the claim appropriately, for the days on which the SNF was in compliance with the assessment schedule (pay the default rate for the days on which the SNF provided covered care, but was not in compliance with the assessment schedule), as described in each of the following situations:

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

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

  - If the facility RUG value obtained through the MDS QC tool matches the RUG code submitted on the claim, the contractor shall pay the claim as billed for all covered days associated with that MDS, even if the level of therapy changed during the payment period (e.g. O.T. is discontinued while medically necessary skilled P.T. services continue).

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

- Some Rehabilitation Services are Reasonable and Necessary but Not **Supported as Billed by the Patient Medical Record:** If some rehabilitation services were appropriate, but some services provided were not reasonable and necessary or were not supported by the medical record as having been provided as billed, and the reviewer determines (based on data entered from the medical record into the MDS QC System Software, version FI-5.01) that

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

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

- **Rehabilitation Services are Not Reasonable and Necessary**-- If all rehabilitation services are determined to be medically unnecessary during the time of the relevant assessment period for the timeframe being billed, but the contractor determines (based on data entered from the medical record into the MDS QC System Software, version FI-5.01) that

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

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

- **Rehabilitation Services Projected On 5-Day Assessment are Not Provided--** If rehabilitation services are not provided at the level projected on the 5-day assessment, the contractor shall look for documentation to support the reason the rehabilitation services were not provided.

  - If documentation supports that the projection was made in good faith, e.g., the physician orders and the therapy plan of treatment reflect the projected level of minutes, and the minimum required minutes were provided, as described in the RAI manual, the contractor shall pay the claim at the RUG level billed for all covered days associated with that MDS.

  - If the documentation does not support that rehabilitation services were reasonable and necessary at the projected level during the 5-day assessment period, adjust the RUG code billed according to the correct RUG value calculated using the MDS QC

System Software for all covered days associated with that MDS, and recoup any overpayments as necessary.

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

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

- **All Rehabilitation Services Become Not Reasonable and Necessary or are No Longer Provided--Skilled Need Continues**-- If the contractor determines that all rehabilitation services are no longer reasonable and necessary, or documentation does not support that any further rehabilitation services were being provided, at some point during the covered days associated with that MDS, but that other medically necessary skilled services were being provided, the contractor shall determine (based on data entered from the medical record into the MDS QC System Software, version FI-5.01) whether there is a clinical group for which the beneficiary qualifies, and pay the claim according to the correct RUG value calculated using the MDS QC System Software, for all covered days associated with that MDS, from the date that the rehabilitation services are determined to be not reasonable and necessary or not provided, and recoup any overpayments as necessary.

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

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

  - **Services are Reasonable and Necessary As Documented on the MDS Submitted to the State Repository**— If no discrepancies are noted between the MDS submitted to the state repository and the patient's medical record, during the relevant assessment period for the timeframe being billed, the contractor shall verify that the RUG

code submitted on the claim matches the RUG code on the MDS imported from the national repository into the MDS QC tool, and:

- If the facility RUG value obtained through the MDS QC tool matches the RUG code submitted on the claim, the contractor shall pay the claim as billed for all covered days associated with that MDS, even if the level of skilled care changed during the payment period.

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

- **Some Services Reasonable and Necessary but Not Supported as Billed in Patient Medical Record**-- If some skilled services were appropriate, but some services provided were not reasonable and necessary or were not supported by the medical record as having been provided as billed, and the reviewer determines (based on data entered from the medical record into the MDS QC System Software, version FI-5.01) that

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

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

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

- HIPPS Codes Indicating Classification into the Lower 18 RUG Groups

- **Lower 18 RUG Group Billed - Level of Care Criteria Met**--If the beneficiary meets the SNF coverage criteria as defined in Section 6.1.3B, the contractor shall accept the claim as billed for the all covered days associated with that MDS, as long as skilled need remains.

- **Lower 18 RUG Group Billed - Level of Care Criteria Not Met**--If the beneficiary does not meet the SNF coverage criteria as defined in Section 6.1.3B, the contractor shall deny the claim in full.

- General Information For All HIPPS Codes

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

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

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

For any full or partial denials made, adjust the claim accordingly to recoup the overpayment. A partial denial based on classification into a new RUG code or a full denial because the level of care requirement was not met are considered reasonable and necessary denials (§1862(a)(1)(A)) and are subject to appeal rights.

It is important to recognize the possibility that the necessity of some services could be questioned and yet not impact the RUG classification. The RUG classification may not change because there are many clinical conditions and treatment regimens that qualify the beneficiary for the RUG group to which he was classified. For instance, a beneficiary who classifies into the Special Care category because he is aphasic, is being tube fed and has a fever would continue to classify into this category even if there is no evidence of fever in the medical record. Although fever with tube feeding is a qualifier for classification into the Special Care category, so is tube feeding with aphasia.

When reviewing bills, if you suspect fraudulent behavior, e.g., a pattern of intentional reporting of inaccurate information for the purpose of payment or the billing for services which were not furnished, it is your responsibility to comply with CMS's Fraud and Abuse guidelines (PIM Chapter 4.)

6.1.4 - Workload

(Rev. 71, 04-09-04)

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

6.1.5 - SNF RUG-III Adjustment Matrices and Outcomes Historical Exhibit

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This exhibit, containing the RUG-III adjustment matrices and examples of medical review conducted based on the matrices, is provided for historical purposes **only**. Contractors are now to utilize the MDS QC System Software for the adjustment of SNF claims.

RUG-III ADJUSTMENT MATRICES

Matrix A

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

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

MATRIX B

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

Special Care – SSB	X	X	CB1	PA1	Deny
Special Care – SSA	X	X	CA1	PA1	Deny
Clinically Complex - CC2, CC1, CB2, CB1, CA2, CA1	X	X	X	PA1	Deny
All Lower 18 RUG III Codes	X	X	X	PA1	Deny

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

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

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

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

To calculate the RUG-III ADL Sum Score:

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

MDS ITEM	**IF COLUMN A**	**IF COLUMN B**	**ADL**	**SCORE**

	VALUE=	VALUE=	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)

The following examples of medical review outcomes are provided, like the RUG-III adjustment matrices, for historical purposes **only**. For claims with dates of service beginning January 1, 2006, contractors have been instructed to utilize the MDS QC software System to adjust SNF claims.

EXAMPLES OF MEDICAL REVIEW OUTCOMES
HIPPS Codes Indicating Classification into a Rehabilitation Group

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

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

Supporting Documentation:

MDS:

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

Medical Record:

- The resident was hospitalized for 8 days for an acute CVA.
- In the 7-day look-back period including the assessment reference date (ARD) he received 450 minutes of therapy.

- The therapy documentation shows that ST, OT & PT are each treating him/her for 30 minutes each day.
- The evaluation and progress notes indicate the patient has deficits in speech, swallowing, activities of daily living (ADLs), range of motion (ROM) and mobility.
- OT is discontinued on the 20th day because the beneficiary's condition had improved.

Review Determination:

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

HIPPS Codes Indicating Classification into a Rehabilitation Group

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

Services Billed: **RUC07 for days 15-30**

Supporting Documentation:

MDS:

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

Medical Record:

- The resident was hospitalized for 8 days with a diagnosis of acute CVA.
- Speech Therapy notes indicated that therapy services were provided BID on 5 days/240 minutes during the look back period.
- Occupational Therapy notes indicated that therapy services were provided BID on 5 days/240 minutes during the look back period.
- Physical Therapy notes indicated that therapy services were provided BID on 5 days/240 minutes.
- Documentation in the nursing notes indicated that the patient complained of being exhausted at the end of the day and requested that BID therapy be discontinued.

Therapy progress notes indicated that the patient participated minimally in his afternoon therapy sessions due to complaints of fatigue.

Review Determination:

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

HIPPS Codes Indicating Classification into a Rehabilitation Group

3. Rehabilitation Services Not Reasonable and Necessary--If all rehabilitation services are determined to be medically unnecessary during the time of the relevant assessment period for the timeframe being billed, use EXHIBIT I to determine if there is a clinical group for which the beneficiary qualified. Based on the selected category, adjust the RUG-III code billed according to Matrix B of Rug-III Adjustment Matrices, EXHIBIT II for the entire payment period.

SCENARIO 3a:

Services Billed: RHB07 for days 15-30

Supporting Documentation:

MDS:

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

Medical Record:

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

Review Determination 3a: No other skilled needs documented

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

SCENARIO 3b:

Services Billed: RHB07 for days 15-30

Supporting Documentation:

MDS:

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

Medical Record:

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

Review Determination 3b: Another skilled need was identified

- The documentation does not support the level billed.
- The HIPPS code billed would be down-coded to SE107 using Matrix B.

HIPPS Codes Indicating Classification into a Rehabilitation Group

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

SCENARIO 4a:

Services Billed: RHC01 for days 1-14

Supporting Documentation:

MDS:

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

Medical Record:

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

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

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

SCENARIO 4b:

Services Billed: RHC01 for days 1-14

Supporting Documentation:

MDS:

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

Medical Record:

- Dr orders and plan of treatment were for all three therapies at 5 days each week.

- There was no documentation to support therapy services being rendered and no rationale as to why they were not provided.

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

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

SCENARIO 4c:

Services Billed: RHC01 for days 1-14

Supporting Documentation:

MDS:

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

Medical Record:

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

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

- Documentation does not support level billed.
- OT and PT were not medically reasonable or necessary to treat this patient's condition.

- ST was medically reasonable and necessary to treat this patient's condition for 30 minutes a day for 5 days per week
- The projection in T1c and T1d would be readjusted to 10days/300 minutes.
- Adjust the RUG-III code billed according to Matrix A of the Rug-III Adjustment Matrices, EXHIBIT II to pay at RMC for the entire payment period.

HIPPS Codes Indicating Classification into a Rehabilitation Group

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

Services Billed: RHC02 for days 31-60

Supporting Documentation:

MDS:

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

Medical Record:

- The patient's qualifying hospital stay resulted from a fractured hip with repair.
- Therapies were found to be discontinued on day 40.
- The resident continued to be treated by nursing for a Stage IV. Decubitus Ulcer with twice a day (BID) medication and dressing, changes which resulted from the immobility caused by the fracture.

Review Determination

- No OMRA was completed by the facility.
- RHC02 would be paid through the 48th day (8 days after therapies discontinued – the first possible day an OMRA could/should have been completed).

- Days 49-60 would be down coded to AAA00 (the default rate), because the documentation does not support level billed.

HIPPS Codes Indicating Classification into a Rehabilitation Group

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

Services Billed: RHC02 for days 31-60

Supporting Documentation:

MDS:

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

Medical Record:

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

Review Determination:

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

HIPPS Codes Indicating Classification into a Rehabilitation Group

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

EXHIBIT II from the date that the rehabilitation services are determined to be not reasonable and necessary.

Services Billed: RHC02 for days 31-60

Supporting Documentation:

MDS:

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

Medical Record:

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

Review Determination:

- Skilled rehab services were no longer R/N after day 45.
- The resident would qualify for the clinically complex category due to his chemotherapy and need for observation and assessment.
- The claim would be paid at RHC02 for days 31-45.
- Using Matrix B days 46-60 would be down-coded to CC102 because documentation does not support medical necessity at the level billed.

HIPPS Codes Indicating Classification into a Rehabilitation Group

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

Services Billed: RHC02 for days 31-60

Supporting Documentation:

MDS:

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

Medical Record:

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

Review Determination:

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

HIPPS Codes Indicating Classification into a Clinical Group

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

Services Billed: SSB07 for days 15-30

Supporting Documentation:

MDS:

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

Medical Record:

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

Review Determination:

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

HIPPS Codes Indicating Classification into a Clinical Group

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

Serviced Billed: SSB07 for days 15-30

Supporting Documentation:

MDS:

- 14 day assessment
- K5b Feeding tube checked
- K6a 4 (76-100%) checked

- K6b 4 (1501-2000cc/day) checked
- M5f surgical wound care checked

Medical Record:

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

Review Determination:

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

HIPPS Codes Indicating Classification into a Clinical Group

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

Services Billed: SSB07 for days 15-30

Supporting Documentation:

MDS:

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

Medical Record:

- The patient was in the acute hospital for the removal of a large tumor.
- Surgical wound care was clearly documented through day 20 when the treatment was discontinued and the wound was documented as healed.
- There were no other documented skilled needs from day 21 through day 30.

Review Determination:

- This claim would be paid at SSB07 for days 15-20.

- Days 21 through 30 would be denied because skilled services were no longer reasonable and necessary.
- The provider would be liable for days 21 through 30.

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

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

Services Billed: BB201 for days 1-7

Supporting Documentation:

MDS:

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

Medical Record:

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

Review Determination:

- This claim would be paid as billed.

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

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

Services Billed: BB201 for days 1-7

Supporting Documentation:

MDS:

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

Medical Record:

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

Review Determination:

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

6.2 - Home Health

(Rev. 82, 07-23-04, Issued 07-23-04, Effective: August 23, 2004, Implementation: August 23, 2004)

6.2.1 - Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home"

(Rev. 82, 07-23-04, Issued 07-23-04, Effective: August 23, 2004, Implementation: August 23, 2004)

A. General Information

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

NOTE: For the purposes of this manual section a favorable decision is a decision that is favorable to the beneficiary. A final appellate decision is a decision at any level of the appeals process where the RO has finally determined that no further appeals will be taken, or where no appeal has been taken and all time for taking an appeal has lapsed.

Promptly pay the claim that was the subject of the favorable final appellate decision. Promptly pay or review based on the review criteria below: All claims that have been denied that are properly pending in any stage of the appeals process.

All claims that have been denied where the time to appeal has not lapsed. All future claims submitted for this beneficiary.

For favorable final appellate decisions issued during a one-year grace period starting on July 1, 2000, and ending June 30, 2001, reopen all denied claims that are subject to the 12-month reopening provision. Promptly pay or review, based on the review criteria below, these reopened claims.

Establish procedures to ensure that medical review of a beneficiary's claim, after the receipt by that beneficiary of a favorable final appellate decision related to "confined to home," is reviewed based on the review criteria below.

Notify the beneficiary and the affected home health agency that the favorable final appellate decision related to "confined to home" will be given "great weight" in evaluating if the beneficiary is "confined to home." Inform them of what steps should be taken if they believe a claim has been denied in error.

Maintain records containing information on the beneficiaries receiving favorable final appellate decision related to "confined to home." These records should include at a minimum the beneficiary's name, HCIN number, service date of the claim that received the favorable final appellate decision and the date of this decision. This information should be made available to CMS upon request.

B. Review Criteria

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

EXAMPLE 1:

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

determinations, with the result that the beneficiary would therefore be treated as "confined to the home" in those determinations.

EXAMPLE 2:

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

6.2.2 - Medical Review of Home Health Demand Bills

(Rev. 82, 07-23-04, Issued 07-23-04, Effective: August 23, 2004, Implementation: August 23, 2004)

As a result of litigation settlements, intermediaries must perform complex medical review on 100% of the home health demand bills.

6.3 – Medical Review of Certification and Recertification of Residents in SNFs

(Rev. 74, 04-23-04)

The Medicare conditions of payment require a physician certification and (when specified) recertification for SNF services. This requirement is explicitly stated in §1814(a)(2) of the Social Security Act. 42 CFR 424.20 details the required contents of the certification and re-certifications and 42 CFR 424.11 specifies that "no specific procedures or forms are required for certification and recertification statements," and that "the provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special **separate** form." Further, 42 CFR § 424.11(c) states, "If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found." Recent decisions by administrative law judges, that CMS believes are fully consistent with law and regulations, reinforce the need for fiscal intermediaries to consider documentation in the beneficiary's medical record beyond a discrete certification or recertification form to determine if the required elements for certification are present.

Claim denials should be made for failure to comply with the certification or re-certification requirements as described in 42 CFR 424.20. Claim denials may not be made for failure to use a certification form or particular format.

6.4 - Medical Review of Rural Air Ambulance Services
(Rev. 102, Issued: 02-01-05, Effective: 01-01-05, Implementation: 02-14-05)

6.4.1 – "Reasonable" Requests
(Rev. 308, Issued: 10-30-09, Effective: 11-30-09, Implementation: 11-30-09)

Rural air ambulance transport shall be considered reasonable and necessary when a physician or other qualified medical personnel orders or certifies the air transport service. A physician or other qualified medical personnel must certify or determine that the individual's condition requires air transport due to time or geographical factors. The following should be considered to be personnel qualified to order air ambulance services:

- Physician,
- Registered nurse practitioner (from the transferring hospital),
- Physician's assistant (from transferring hospital),
- Paramedic or EMT (at the scene), and
- Trained first responder (at the scene).

6.4.2 – Emergency Medical Services (EMS) Protocols
(Rev. 308, Issued: 10-30-09, Effective: 11-30-09, Implementation: 11-30-09)

Per Section 415 of the Medicare Modernization act of 2003, the reasonable and necessary requirement for rural air transport may be "deemed" to be met when the service is provided pursuant to an established State or regional emergency medical services (EMS) agency protocol. CMS defines "established" to mean those protocols, which have been reviewed and approved by State EMS agencies or have been developed according to State EMS umbrella guidelines. Additionally, the protocol must be recognized or approved by the Secretary.

The information on the FI, carrier, or MAC Web site must inform rural air ambulance providers that if they anticipate transport based upon the contents of such a protocol (either State or regional) they must submit that protocol in advance to the fiscal intermediaries, carriers, or MACs for review and approval. Include instructions on the Web site for submitting the protocol. The contractor will review the protocol to ensure that the contents are consistent with statutory requirements at 1862(a)(1)(A), which direct that all services paid for by Medicare must be reasonable and necessary for the diagnosis or treatment of an illness or injury. The contractor shall make a determination regarding the protocol and/or subsequent revisions and notify the rural air ambulance provider of their determination within 30 days of receipt of the protocol.

Approval of a protocol does not exempt the provider from requirements in the Act at 1861(s)(7) and regulatory requirements at 42 CFR 424.106 which outlines the criteria for determining whether the hospital was the most accessible. Regardless of protocol instructions regarding transport locations Medicare payment can be made only to the closet facility capable of providing the care needed by the beneficiary.

6.4.3 – Prohibited Air Ambulance Relationships
(Rev. 102, Issued: 02-01-05, Effective: 01-01-05, Implementation: 02-14-05)

Do not apply the "deemed" reasonable and necessary determination if there is a financial or employment relationship between the person requesting the air ambulance service and the entity furnishing the service; an entity under common ownership with the entity furnishing the service; or a financial relationship between an immediate family member of the person requesting the service and the entity furnishing the service. Only one exception is available for this provision. When the referring hospital and the entity furnishing the air ambulance services are under common ownership, the above limitation does not apply to remuneration by the hospital for provider based physician services furnished in a hospital, reimbursed under Part A and the amount of the remuneration is unrelated directly or indirectly to the provision of air ambulance services.

6.4.4 – Reasonable and Necessary Services
(Rev. 308, Issued: 10-30-09, Effective: 11-30-09, Implementation: 11-30-09)

When data analysis indicates, fiscal intermediaries, carriers, or MACs may perform medical review of rural air ambulance claims in those instances noted in the above paragraph where there is financial or employment relationship between the person requesting an air ambulance transport and the person providing the service. The fiscal intermediaries, carriers, or MACs may also conduct medical review of rural air ambulance claims with "deemed" medical necessity status when there are questions as to whether the transport was made pursuant to a protocol which has been approved by the Secretary; or questions as to whether the transport was inconsistent with an approved protocol. Medicare payment can be made only to the closest facility capable of providing the care needed by the beneficiary irrespective of whom orders the transport.

6.4.5 – Definition of Rural Air Ambulance Services
(Rev. 102, Issued: 02-01-05, Effective: 01-01-05, Implementation: 02-14-05)

For purposes of this section the term "rural air ambulance service" means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in Section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the **Federal Register** on February 27, 1992 (57 Fed. Reg. 6725).

6.5 - Medical Review of Inpatient Hospital Claims
(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

During the first phase in which FIs and MACs assume responsibility for the review of acute inpatient prospective payment system (IPPS) hospital and long term care hospital (LTCH) claims (which, for the purposes of this section, also includes any hospital that

would be subject to the IPPS or LTCH PPS had it not been granted a waiver) CMS will provide additional funding to facilitate adequate oversight of inpatient hospital claims and reporting of findings from the implementation date of this change request through March 31st, 2009. With this additional funding, contractors will be required to perform data analysis, medical review, and reporting of findings on these IPPS and LTCH PPS hospital claims.

As a part of this specially-funded first-phase initiative, contractors will be permitted to perform random postpayment review of IPPS hospital LTCH claims in order to develop baseline data on utilization. The data compiled through this first-year initiative will serve to help FIs and MACs effectively target future medical review interventions.

The contractor shall submit the one-time final report to the appropriate CMS contact at the end of the first phase.

Instructions in the subsequent sections are not limited to the first phase of IPPS hospital and LTCH claim review. They apply to the review of all IPPS hospital and LTCH claims.

6.5.1 - Screening Instruments

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The reviewer shall use a screening tool as part of their medical review of acute IPPS and LTCH claims. CMS does not require that you use a specific criteria set. In all cases, in addition to screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.

The following shall be utilized as applicable, for each case:

- Admission criteria;
- Invasive procedure criteria;
- CMS coverage guidelines;
- Published CMS criteria
- DRG validation guidelines;
- Coding guidelines; and
- Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community)

Contractors shall consult with physician or other specialists if necessary to make an informed medical review determination.

6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The FIs and MACs shall conduct review of medical records for inpatient acute IPPS hospital and LTCH claims, as appropriate, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

A. Determining Medical Necessity and Appropriateness of Admission

The reviewer shall consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. When such factors affect the beneficiary's health, consider them in determining whether inpatient hospitalization was appropriate.

Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay. See Pub. 100-02, chapter 1, §10 for further detail on what constitutes an appropriate inpatient admission.

B. Determining Whether Covered Care Was Given at Any Time During a Stay in a PPS Hospital

When the contractor determines that the beneficiary did require an inpatient level of care on admission, utilize the medical record to determine whether procedures and diagnoses were coded correctly. If the medical record supports that they were, pay the claim as billed. If the medical record supports that they were not, then utilize ICD-9-CM coding guidelines to adjust the claim and pay at the appropriate DRG. See section 6.5.4 of this chapter for further details on DRG validation review.

When you determine that the beneficiary did not require an inpatient level of care on admission, but that the beneficiary's condition changed during the stay and inpatient care

became medically necessary, you shall review the case in accordance with the following procedures:

- The first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission;

- The deemed date of admission applies when determining cost outlier status (i.e., days or services prior to the deemed date of admission are excluded for outlier purposes); and

- The diagnosis determined to be chiefly responsible for the beneficiary's need for covered services on the deemed date of admission is the principal diagnosis.

- Adjust the claim according to the diagnosis determined to be responsible for the need for medically necessary care to have been provided on an inpatient basis.

When you determine that the beneficiary did not require an inpatient level of care at any time during the admission, deny the claim in full.

6.5.3 - DRG Validation Review

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The contractor shall perform DRG validation on PPS, as appropriate, reviewing the medical record for medical necessity and DRG validation. The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. Reviewers shall validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

NOTE: For PPS waived/excluded areas, review shall be performed appropriate to your area.

A. Coding

The contractor shall use individuals trained and experienced in ICD-9-CM coding to perform the DRG validation functions. The validation is to verify the accuracy of the hospital's ICD-9-CM coding of all diagnoses and procedures that affect the DRG.

The contractor shall base DRG validation upon accepted principles of coding practice, consistent with guidelines established for ICD-9-CM coding, the Uniform Hospital Discharge Data Set data element definitions, and coding clarifications issued by CMS. The contractor shall not change these guidelines or institute new coding requirements that do not conform to established coding rules.

The contractor shall verify a hospital's coding in accordance with the coding principles reflected in the ICD-9-CM Coding Manual. Contractors shall use the ICD-9 CM version in place at the time the services were rendered, and the official National Center for Health Statistics and CMS addenda, which update the ICD-9-CM Manual annually. The annual addenda are effective on October 1 of each year and apply to discharges occurring on or after October 1. The contractor shall use only ICD-9-CM Manual volumes based on official ICD-9-CM Addendum and updates when performing DRG validation.

Hospitals are not required to code minor diagnostic and therapeutic procedures (e.g., imaging studies, physical, occupational, respiratory therapy), but may do so at their discretion.

B. Diagnoses

Contractors shall ensure that the hospital reports the principal diagnosis and all relevant secondary diagnoses on the claim. The relevant diagnoses are those that affect DRG assignment. The hospital must identify the principal diagnosis when secondary diagnoses are also reported. When a comorbid condition, complication, or secondary diagnosis affecting the DRG assignment is not listed on the hospital's claim but is indicated in the medical record, insert the appropriate code on the claim form. If the hospital already reported the maximum number of diagnoses allowed on the claim form, delete a code that does not affect DRG assignment, and insert the new code.

The contractor is not required to additional diagnoses on the claim as long as all conditions that affect the DRG are reflected in the diagnoses already listed, and the principal diagnosis is correct and properly identified. The hospital can list the secondary diagnoses in any sequence on the claim form because the GROUPER program will search the entire list to identify the appropriate DRG assignment.

- Principal Diagnosis – The contractor shall determine whether the principal diagnosis listed on the claim is the diagnosis which, after study, is determined to have occasioned the beneficiary's admission to the hospital. The principal diagnosis (as evidenced by the physician's entries in the beneficiary's medical record) (see 42 CFR 412.46) must match the principal diagnosis reported on the claim form. The principal diagnosis must be coded to the highest level of specificity. For example, a diagnosis from chapter 16 of the ICD-9-CM Coding Manual, "Symptoms, Signs, and Ill-defined Conditions," may not be used as the principal diagnosis when the underlying cause of the beneficiary's condition is known.

- Inappropriate Diagnoses – The contractor shall exclude diagnoses relating to an earlier episode that have no bearing on the current hospital stay. Delete any incorrect diagnoses and revise the DRG assignment as necessary.

C. Procedures

The contractor shall ensure that the hospital has reported all procedures affecting the DRG assignment on the claim. If there are more procedures performed than can be listed on the claim, verify that those reported include all procedures that affect DRG assignment, and that they are coded accurately. See section 6.5.4 below for further detail on reviewing procedures.

6.5.4 – Review of Procedures Affecting the DRG

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

The contractor shall determine whether the performance of any procedure that affects, or has the potential to affect, the DRG was reasonable and medically necessary. If the admission and the procedure were medically necessary, but the procedure could have been performed on an outpatient basis if the beneficiary had not already been in the hospital, do not deny the procedure or the admission.

When a procedure was not medically necessary, the contractor shall follow these guidelines:

If the admission was for the sole purpose of the performance of the non-covered procedure, and the beneficiary never developed the need for a covered level of service, deny the admission;

If the admission was appropriate, and not for the sole purpose of performing the procedure, deny the procedure (i.e., remove from the DRG calculation), but approve the admission;

If performing a cost outlier review, in accordance with Pub. 100-10, chapter 4, §4210 B, and the beneficiary was in the hospital for any day(s) solely for the performance of the procedure or care related to the procedure, deny the costs for the day(s) and for the performance of the procedure; and

If performing a cost outlier review, and the beneficiary was receiving the appropriate level of covered care for all hospital days, deny the procedure or service.

See Pub. 100-02, *C*hapter 1, §10 for further detail on payment of inpatient claims containing non-covered services.

6.5.5 – Special Review Considerations

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Refer to Pub. 100-04, chapter 3, §20 C. for information regarding handling of claims with DRG 468. This DRG represents a discharge with valid data but where the surgical procedure is unrelated to the principal diagnosis.

Refer to 100-04, chapter 3, §20.2.1, subsection D.9. for a description of questionable admission ICD-9-CM codes. FIs and MACS may wish to consider including these diagnoses in their data analysis.

For a listing of ICD-9-CM diagnosis codes identified as "questionable admission" codes see the Medicare Code Editor (MCE) Web site at:
http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1206058&intNumPerPage=10

Refer to 100-04, chapter 3, §20.2.1, subsection D.10 for a description of diagnoses which are acceptable only when coded with a secondary diagnosis. FIs and MACs may wish to include these diagnoses in their data analysis as the MCE will not reject them when they are billed with a secondary diagnosis.

For a listing of ICD-9-CM diagnosis codes that are acceptable only when coded with a secondary diagnosis see the MCE Web site at:
http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1206058&intNumPerPage=10

6.5.6 - Length-of-Stay Review

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The contractor shall determine whether the length-of-stay for PPS cost outlier claims and specialty hospital/unit claims, when selected for medical review, is appropriate and medically necessary. Identify cases of potential delayed discharge. For example, the beneficiary was medically stable, and continued hospitalization was unnecessary, or nursing home placement or discharge to home with home care would have been appropriate in providing needed care without posing a threat to the safety or health of the beneficiary (see §4110).

If Medicare payment is applicable to only part of the stay, review the covered portion of the stay and enough of the rest of the medical record (if necessary) to answer any specific questions that may arise from review of the covered part of the stay. If a beneficiary became Medicare eligible during a hospital stay, review enough of the medical record prior to the initiation of Medicare benefits to acquire sufficient information to make a determination. Do not perform lengthy reviews of non-covered care. In PPS waived/excluded areas, length-of-stay review is performed for all inpatient admissions that are selected for medical review.

The contractor shall determine whether the length of stay was appropriate for claims selected for medical review that represent PPS cost outliers. However, the contractor shall not include days on which care is determined not to have been medically necessary in the calculation of outlier payments. Where it is determined that a beneficiary's stay

was unnecessarily long, and potentially represents fraud or abuse, the contractor shall make a referral to the PSC/ZPIC.

6.5.7 - *Reserved for Future Use*

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

6.5.8 - *Reserved for Future Use*

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

6.5.9 - Circumvention of PPS

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

If you suspect, during review of a claim associated with a transfer or readmission, that a provider of Medicare services took an action with the intent of circumventing PPS (as described in §1886(f)(2) of the Act) and that action resulted in unnecessary admissions, premature discharges and readmissions, multiple readmissions, or other inappropriate medical or other practices with respect to beneficiaries or billing for services, you shall make a referral to your *Zone Program Integrity Contractor (ZPIC).*

6.6 - Referrals to the Quality Improvement Organization (QIO)

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

The MACs shall only refer Quality of (Health) Care Concerns to the QIOs. A Quality of (Health) Care Concern is defined as "a concern that care provided did not meet a professionally recognized standard of health care." The Contractor shall follow the referral process as agreed upon in the QIO-MAC Joint Operating Agreement. The QIOs will retain their responsibility for performing expedited determinations, Hospital-Issued Notices of Non-Coverage (HINN) reviews, quality reviews, transfer reviews, readmission reviews and, provider-requested higher-weighted DRG reviews.

The Circumvention of PPS will continue to be reported to your Zoned Program Integrity Contactor (ZPIC). The quality initiatives associated with payment for performance are now the reporting source for Readmission Reviews and Transfer Review data to the QIOs. Non-covered benefits/services are not to be reported to the QIO.

All initial payment determinations and claim adjustments are required to be performed by the MAC.

All MACs are to turn off all automated edits/processes that generate a referral to the QIOs prior to a complex medical review of the claim. Referrals to the QIO shall be limited to Quality of Health Care issues as defined above and shall result from a clinician's complex medical review of a provider's medical documentation.

If during the complex medical review process, "a concern that care provided did not meet a professionally recognized standard of health care," the MAC shall issue a payment determination and/or adjustment for the claim, complete the QIO referral form,

and forward the completed referral form and file(s) to the QIO. If the referral form is not complete, the QIO will return the file to the MAC and request that the MAC provide the missing information prior to the QIO performing a review.

A non-covered service and/or procedure shall not be automatically referred to the QIO. The MAC shall make the initial payment determination and/or claim adjustment for a non-covered service or procedure in accordance with the Medicare IOM 100-04, Claims Processing Manual and IOM 100-02, Benefit Policy Manual.

If during the complex medical review process, "a concern that care provided did not meet a professionally recognized standard of health care," such as a medically unnecessary procedure, the claim shall be referred to the QIO for quality review after payment determination and/or claim adjustment is made.

The MACs shall not instruct providers, suppliers, or beneficiaries to refer payment issues to the QIO. If the provider or supplier does not agree with the payment and/or claim adjustment decision, the MAC shall communicate their options to follow the current process in IOM 100-08, requesting a reopening or an appeal. If the beneficiary disagrees with the payment decision and makes a request for re-evaluation/redetermination, this will be considered a demand bill and is the responsibility of the MAC.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R475PI	07/19/2013	PIM Chapter 6 MR Guidelines 6.54-6.5.7 Update	08/19/2013	8379
R308PI	10/30/2009	Rural Air Ambulance	11/30/2009	6682
R264PI	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849
R196PI	03/30/2007	Medical Review of Skilled Nursing Facility (SNF) Claims Using the MDS QC System Software	04/30/2007	5418
R174PI	11/17/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
R171PI	11/03/2006	Transition of Medical Review Educational Activities – Replaced by Transmittal 174	10/06/2006	5275
R163PI	09/29/2006	Transition of Medical Review Educational Activities – Replaced by Transmittal 170	10/06/2006	5275
R102PI	02/01/2005	Medical Review of Rural Air Ambulance Services	02/14/2005	3571
R093PI	01/14/2005	Medical Review of Rural Air Ambulance Services - Replaced by Transmittal 102	02/14/2005	3571
R082PI	07/23/2004	Home Health Demand Bills	08/23/2004	3266
R074PI	04/23/2004	SNF Certification and Recertification	05/24/2004	3150
R071PI	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
R042PI	06/20/2003	Intermediary Medical Review Guidelines	07/01/2003	2720
R026PIM	04/27/2002	Deletes Section 1.7 Quality Issues in SNF and Referral to other Agencies	N/A	2100
R023PIM	03/18/2002	Revises and clarifies HHAs Certification and Plan of Care Data	05/02/2002	1981
R020PIM	02/21/2002	Revises Terminology used in Chap 6,sec 12 MR of Ambulance Services	04/01/2002	1974
R018PIM	01/17/2002	Manualizes PM A-00-08, Revises the existing SNF MR guidelines	N/A	1064
R015PIM	10/29/2001	MR of Partial Hospitalization Claims,	12/13/2001	1831
R003PIM	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292
R002PIM	9/15/2000	Intermediary MR Guidelines for Specific Services	NA	882

Rev #	Issue Date	Subject	Impl Date	CR#
R001PIM	06/2000	Initial Release of Manual	NA	931

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