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SNF Town Hall - Documentation Requirements and Medical Review

12/20/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Kathy Mersch

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Objectives

- After this session, attendees will be able to:
  - Understand how the Patient-Driven Payment Model (PDPM) works with the MDS
  - Utilize knowledge of CMS SNF coverage and documentation requirements to properly determine covered services and document the medical record
  - Prevent common documentation errors and avoid claim denials
  - Discuss the National Government Services Targeted Probe and Educate/Clinical Review Nurse Process

Agenda

- Patient-Driven Payment Model
- CMS SNF Coverage and Documentation Requirements
- Common Documentation Errors
- National Government Services Clinical Review Nurse Process
- References and Resources
- Questions and Answers

Patient-Driven Payment Model (PDPM)

PDPM Overview

- Case-mix classification system for classifying SNF patients in Medicare Part A covered stays into payment groups under SNF PPS
  - Implemented nationwide effective 10/1/2019
  - Replaced case-mix classification system, the Resource Utilization Group – Version 4 (RUG-IV)

PDPM Assessments

- Only two types under PDPM
  - One required (five-day assessment)
  - One optional (Interim Payment Assessments (IPA))
- Assessments cannot be combined and must be done in order
- Assessment Reference Date (ARD) = Last day of observation period that assessment covers

PDPM Assessments

- Must enter assessment information into MDS to obtain information for coding claims
  - MDS 3.0 RAI Manual v1.17.1_October 2019 (cms.gov)

PDPM Assessment Schedule

Medicare MDS Assessment Type	Assessment Reference Date (ARD)	Applicable Standard Medicare Payment Days
Five-Day Scheduled PPS Assessment	Days 1-8	All covered Part A days until discharge (unless an IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	ARD of assessment through Part A discharge (unless another IPA is completed)
PPS Discharge Assessment	PPS Discharge: Equal to end date of most recent Medicare stay (A2400C) or end date	N/A

PDPM Assessments

- Interim Payment Assessment (IPA) - Optional
  - May be completed by providers in order to report change in patient's PDPM classification
    - Does not impact variable per diem payment schedule
  - ARD (Item A2300) set for any day of SNF PPS stay, beyond ARD of five-day assessment
    - Must be completed (Item Z0500B) within 14 days after ARD
  - Payment Impact
    - Changes payment beginning on ARD and continues until end of Part A stay or until another IPA completed

Late Assessments

- For late assessments under PDPM, provider bills
  - Default HIPPS code (ZZZZZ) for number of days out of compliance
  - Then five-day assessment HIPPS code for remainder of stay (unless IPA done)
- Since IPA is completely optional, no late assessment penalties for that assessment

Interrupted Stay Policy

- Patient discharged from SNF and readmitted to same SNF no more than three consecutive calendar days after discharge
  - Subsequent stay considered continuation of previous stay
  - Assessment schedule continues from point just prior to discharge
  - Variable per diem schedule continues from point just prior to discharge

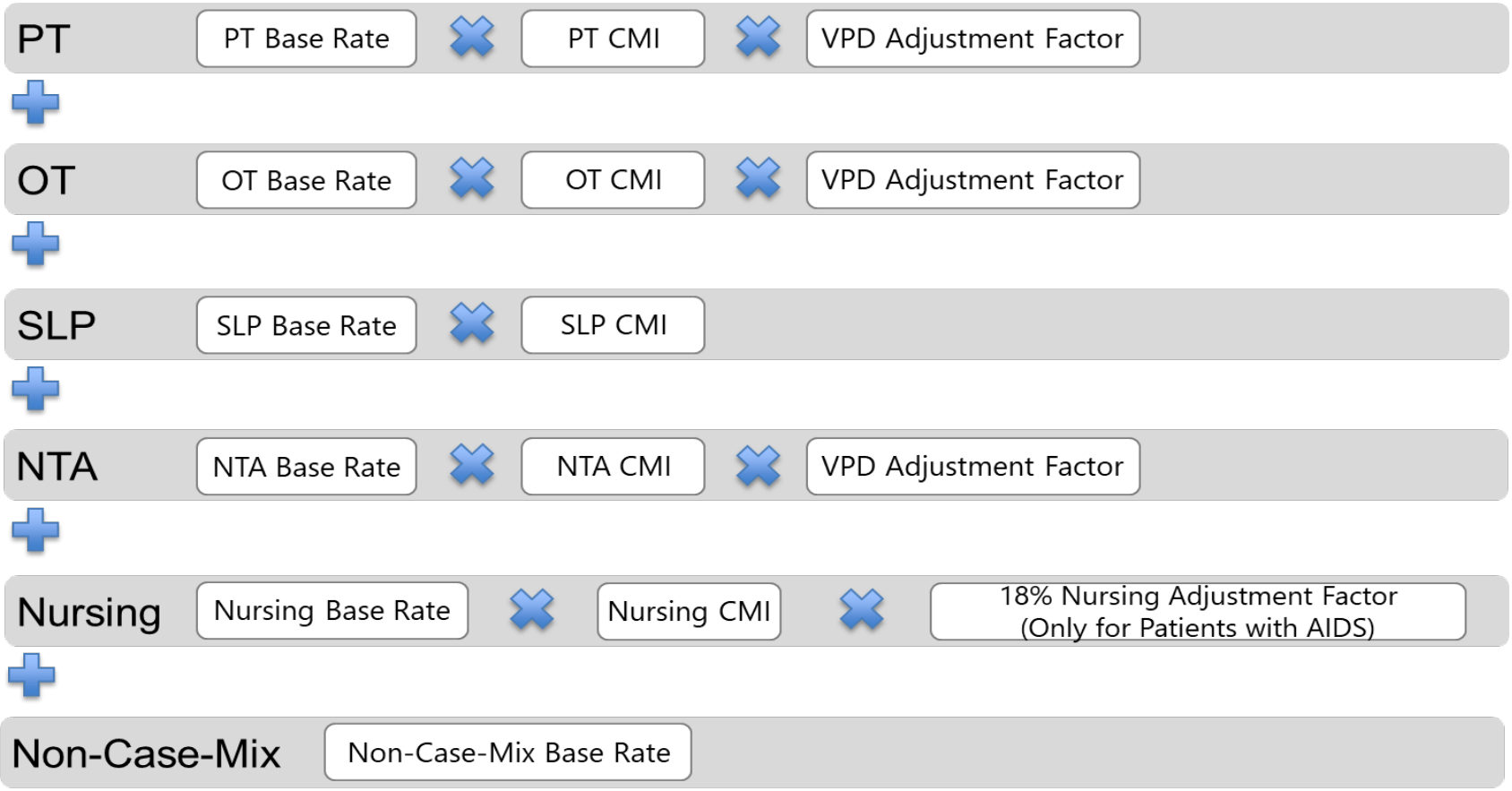
PDPM Patient Classification

- Each patient classified into group for each of five case-mix adjusted components
  - PT: Clinical Category, Functional Score
  - OT: Clinical Category, Functional Score
  - SLP: Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder
  - Nursing: Same characteristics as under RUG-IV
  - NTA: NTA Comorbidity Score

PDPM HIPPS Coding

- Based on responses on MDS, patient classified into payment groups which are billed using five-character HIPPS code
- PDPM HIPPS structure:
  - Character 1: PT/OT Payment Group
  - Character 2: SLP Payment Group
  - Character 3: Nursing Payment Group
  - Character 4: NTA Payment Group
  - Character 5: Assessment Indicator

PDPM Snapshot



PDPM HIPPS Coding: Default Billing

- Default rate refers to lowest possible rate
  - Used in cases such as where assessment performed late
- Default code under PDPM (ZZZZZ) represents sum of lowest per diem rate under each PDPM component, plus non-case-mix component
- Variable per diem schedule must still be followed

CMS SNF Coverage and Documentation Requirements

Skilled Nursing Facility Level of Care

- All four factors must be met
  - Patient requires skilled nursing services or skilled rehabilitation services
    - Must be performed by or under supervision of professional or technical personnel
    - Ordered by physician
    - Rendered for condition
      - For which patient received inpatient hospital services, or
      - That arose while receiving care in SNF for condition for which patient received inpatient hospital services

Skilled Nursing Facility Level of Care

- Patient requires these skilled services on daily basis
- As practical matter, daily skilled services can be provided only on inpatient basis in SNF setting
- Services delivered are reasonable and necessary for treatment of patient's illness or injury
  - Consistent with
    - Nature and severity of patient's illness or injury
    - Patient's particular medical needs
    - Accepted standards of medical practice
  - Reasonable in terms of duration and quantity

Skilled Nursing Facility Level of Care

- If any one of these four factors not met, SNF stay not covered
  - Even though it might include delivery of some skilled services (example - intermittent rather than daily skilled services needed)

Principles for Determining Whether Service Skilled

- Inherent complexity of service prescribed for patient can only be performed safely and/or effectively by or under general supervision of skilled nursing or skilled rehabilitation personnel
  - Examples
    - Administration of intravenous feedings and intramuscular injections
    - Insertion of suprapubic catheters
    - Ultrasound, shortwave, and microwave therapy treatments

Principles for Determining Whether Service Skilled

- A/B MAC considers nature of service and skills required for safe and effective delivery of that service in deciding whether service skilled
  - Patient's diagnosis or prognosis should never be sole factor in deciding that service not skilled
  - EXAMPLE: Rehabilitation services are primary services
    - Key issue - whether skills of therapist needed
    - Deciding factor not patient's potential for recovery, but whether services needed require skills of therapist or could be provided by nonskilled personnel

Principles for Determining Whether Service Skilled

- Service ordinarily considered nonskilled could be considered skilled where special medical complications, skilled nursing or skilled rehabilitation personnel required to perform or supervise service or to observe patient
  - Complications/special services involved must be documented by physicians' orders and notes as well as nursing or therapy notes

Principles for Determining Whether Service Skilled

- EXAMPLE: Whirlpool baths
  - Do not ordinarily require skills of qualified physical therapist
  - Skills, knowledge, and judgment of qualified physical therapist might be required where patient's condition complicated by circulatory deficiency, areas of desensitization, or open wounds
  - Documentation needs to support severity of circulatory condition that requires skilled care

Principles for Determining Whether Service Skilled

- Necessary to determine whether individual services skilled, or in light of patient's total condition, were skilled management of services provided needed if many/all of specific services unskilled

Principles for Determining Whether Service Skilled

- EXAMPLE: 81-year-old woman aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered cerebrovascular accident, is incontinent, has Stage 1 decubitus ulcer, and unable to communicate and make her needs known
  - Even though no specific service provided skilled, patient's condition requires daily skilled nursing involvement to manage plan for total care needed, to observe patient's progress, and to evaluate need for changes in treatment plan
  - Medical condition of patient must be described and documented to support goals for patient and need for skilled nursing services

Principles for Determining Whether Service Skilled

- Importance of particular service to individual patient, or frequency with which it must be performed, does not, by itself, make it skilled
  - EXAMPLE: Primary need of nonambulatory patient may be frequent changes of position in order to avoid development of decubitus ulcers
    - However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute skilled service, even though such services obviously necessary

Principles for Determining Whether Service Skilled

- Possibility of adverse effects from improper performance of otherwise unskilled service does not make it skilled service unless there documentation to support need for skilled nursing or skilled rehabilitation personnel
  - EXAMPLE: Act of turning patient - normally not skilled
    - Sometimes skills of nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities
    - Reasons why skilled nursing or skilled rehabilitation personnel essential must be documented in patient's medical record

Documentation to Support Skilled Care Determinations

- Documentation must show
  - Skilled involvement required in order for services in question to be furnished safely and effectively
  - Services themselves reasonable and necessary for treatment of patient's illness or injury
    - Consistent with nature and severity of individual's illness or injury, individual's particular medical needs, and accepted standards of medical practice
  - Services appropriate in terms of duration and quantity, and services promote documented therapeutic goals

Documentation to Support Skilled Care Determinations

- Document in medical record (as appropriate)
  - History and physical exam pertinent to care provided (including response or changes in behavior to previously administered skilled services)
  - Skilled services provided
  - Patient's response to skilled services provided during current visit
  - Plan for future care based on rationale of prior results

Documentation to Support Skilled Care Determinations

- Detailed rationale explaining need for skilled service in light of patient's overall medical condition and experiences
- Complexity of service to be performed
- Any other pertinent characteristics of patient

- Documentation must be accurate and avoid vague/subjective descriptions of patient's care that would not be sufficient to indicate need for skilled care

Common Documentation Errors

Therapy Documentation Checklist

- Initial evaluation including treatment plan/ reevaluations
- Certification/recertification related to service dates of claim reviewed
  - Physician/NPP approval of therapy plan of care
  - Acknowledges type of therapy (amount, frequency and duration) and for what purpose (goals)
  - Approval of plan of care makes certification different than order/referral (unless it includes plan of care)

Therapy Documentation Checklist

- Documentation required for every treatment day and every therapy service
  - Regardless if daily therapy service provided in SNF, CORF, IRF, HHA or outpatient program
  - Daily requirement - CMS Internet Only Manual Publication 100-02 *Medicare Benefit Policy Manual,* Chapter 15, Section 220.A
  - Specificity requirements - CMS Internet Only Manual Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 220.15.E

Therapy Documentation Checklist

- Daily treatment notes and exercise/activity logs must include
  - Identification of interventions provided
  - Total timed code treatment minutes
  - Total treatment time in minutes
- Progress reports since onset of therapy
- Discharge note, if completed

Issue: Therapy Certifications

- Must state patient in SNF for diagnosis related to inpatient stay
- Cannot be signed after discharge

Issue: Lack of Daily Therapy Treatment Notes

- Documentation required for every treatment day, and every therapy service
  - Need for skilled therapy and skills of therapist must be clearly written in notes
    - Therapist can provide the treatment note in any format, as long as it provides "sufficient documentation"
    - Matrix log insufficient as "daily documentation"
  - Interventions provided need to be clearly documented
    - Create record of all treatments and skilled interventions provided and to record time of services

MDS/PDPM

- Nursing Category utilizes the following to assign patient to nursing case-mix group
  - Use of extensive services
  - Certain clinical conditions
  - Presence of depression
  - Restorative nursing services provided
  - Patient's functional score
- MDS 3.0 Manual chart (page 663 – 665)

Issue: MDS Nursing Category

- Rating patient as special care high when documentation in medical record does not support this

Issue: Look Back Periods

- Not documented appropriately (some go back into hospital stay)

MDS items that do not have a 7-day look back	
D0100 Resident Mood Interview (PHQ9)	14-day look back (p. 173)
D0500 Staff Assessment of Resident Mood (PHQ-9-OV)	14-day look back (p. 180)
Section I: Diagnosis Identification	60-day look back (p. 352)
Section I: Diagnosis Status	7-day look back except for Item I2300 UTI which has a 30 day look back (p. 357)
K0200B, K0300 weight and weight loss, K0310 weight gain	30 day look back for weight, 30 day and 180 day look back for weight loss/gain
O0100A - O0100Z Special Treatments, Procedures & Programs	14-day look back

Issues: MDS Coding

- J1100 shortness of breath (dyspnea)
  - Diagnosis being used inappropriately
- 00400D Respiratory Therapy
  - Being used for patients with no history of respiratory issues
  - No supporting documentation for this service

Respiratory Therapy

- Documentation requirements
  - Physician's initial order or referral
  - Diagnosis for therapy services including date of onset
  - Initial evaluation and all reevaluations
  - Plan of treatment pertaining to this claim period
  - Progress notes and attendance records pertaining to this claim period to support total minutes of actual treatment and number of minutes for each modality
  - Clinic progress notes

Respiratory Therapy

- Laboratory, radiology, and any other diagnostic reports pertinent to services billed
- ABN (if issued)
- Itemized bill

- About Appeals - NGSMEDICARE

Other Recent Errors

- IV fluids while NOT a resident (patient on IV antibiotics not IV fluid)
- IVF should be given to RX dehydration
  - Record often does not support goal of hydration or that dehydration is an issue
- Missing diagnosis (mostly COPD)
- Diagnosis not an active diagnosis
  - SLP CVA/TIA/stroke – Placed on MDS when it happened years ago (not active diagnosis) and no deficits

National Government Services Clinical Review Nurse Process

TPE Process

- MAC selects topics for review based upon existing data analysis procedures
- Claim sample size for each round of probe review limited to minimum of 20 and maximum of 40 claims
  - Sample size - per provider, per topic and per round
- Up to three rounds of medical review
  - Round 1 = post-payment review
  - Rounds 2 and 3 = pre-payment review

TPE Process

- Providers targeted for TPE will receive –
  - Notification letter (enclosed in pink envelope) about upcoming review
  - Specific claims selected for review
    - Round 1 – ADRs sent
    - Rounds 2 and 3 – List sent with notification letter
- Respond promptly to notification letter with name, phone number and email address of point of contact for TPE-related issues

TPE Process

- Ensure medical records submitted promptly
  - For prepayment TPE, individual ADRs sent for each claim selected for review
    - Mailed to either "Pay To" or "Practice Location" address designated on your enrollment application to NGS
    - For post-payment TPE, notification letter with list of claims selected for review considered to be ADR for that round
  - Make sure to submit all components requested, coordinate with clinical staff members to ensure all clinical components included in documentation

TPE Process

- ADRs must be responded to prior to 45 day deadline (based on date of ADR) for each claim selected
  - Reach out with any questions about what to submit and/or other TPE questions
  - Suggest to utilize NGSConnex to submit documentation
  - Provider nonresponse to medical records requests counts as error

TPE Process

- Sample of claims reviewed for round by clinical review nurse
  - Evaluates claim documentation reads entire medical record submitted when making payment decision
  - May provide informal intra-probe education as trends and issues identified during claim review
- After all sample claims reviewed, education will be offered via Results Letter
  - Sent to attention of provider's Compliance Officer

TPE Process

- If error rate is greater than 15%, provider will receive education specific to reason(s) for denial and will be moved to next round
  - Providers with error rate of greater than 15% that do not request or accept education will be noted as a refusal
  - End of Round Education - formal education session provided by Case Management Team

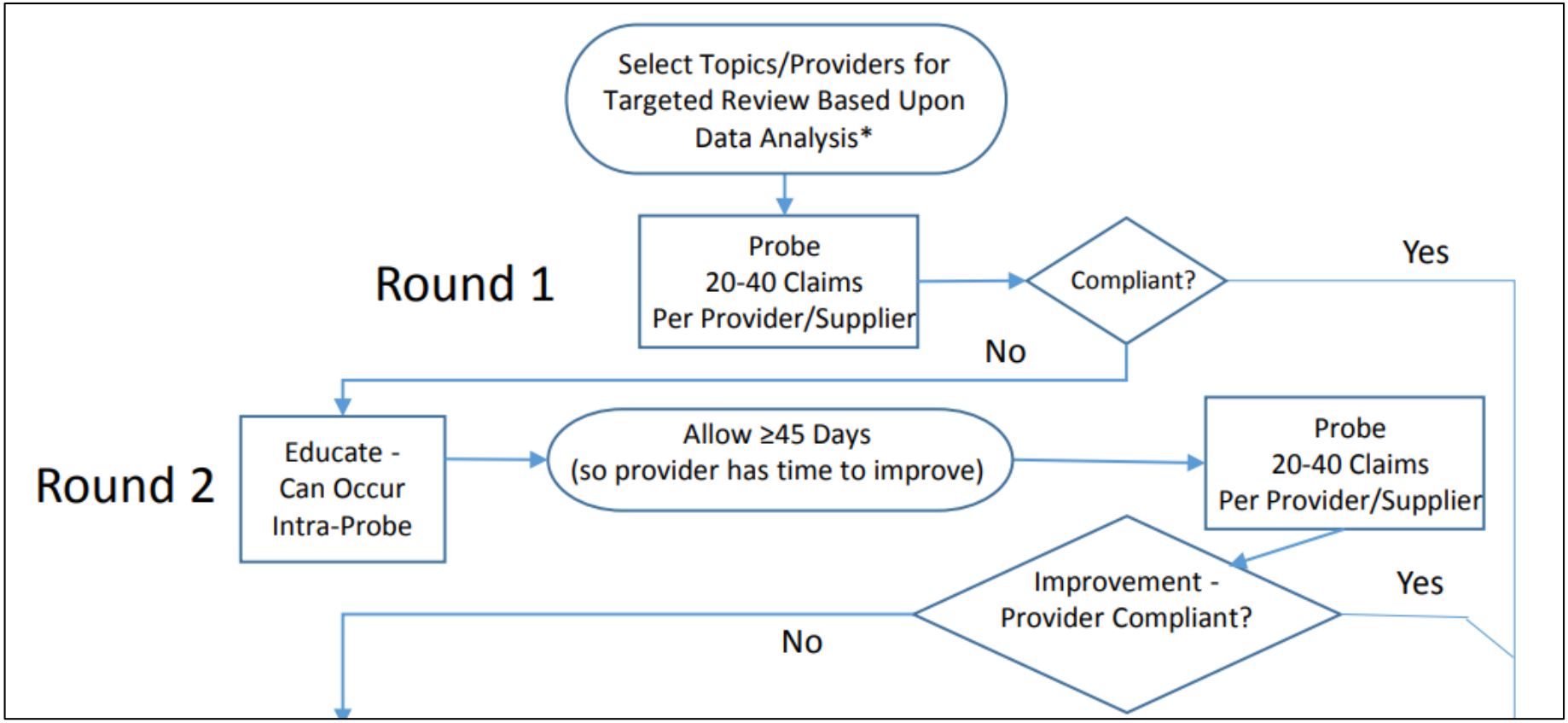
TPE Process

- Up to three rounds of review and educational opportunities
  - Providers with continued high error rate after three rounds of TPE referred to CMS for additional action

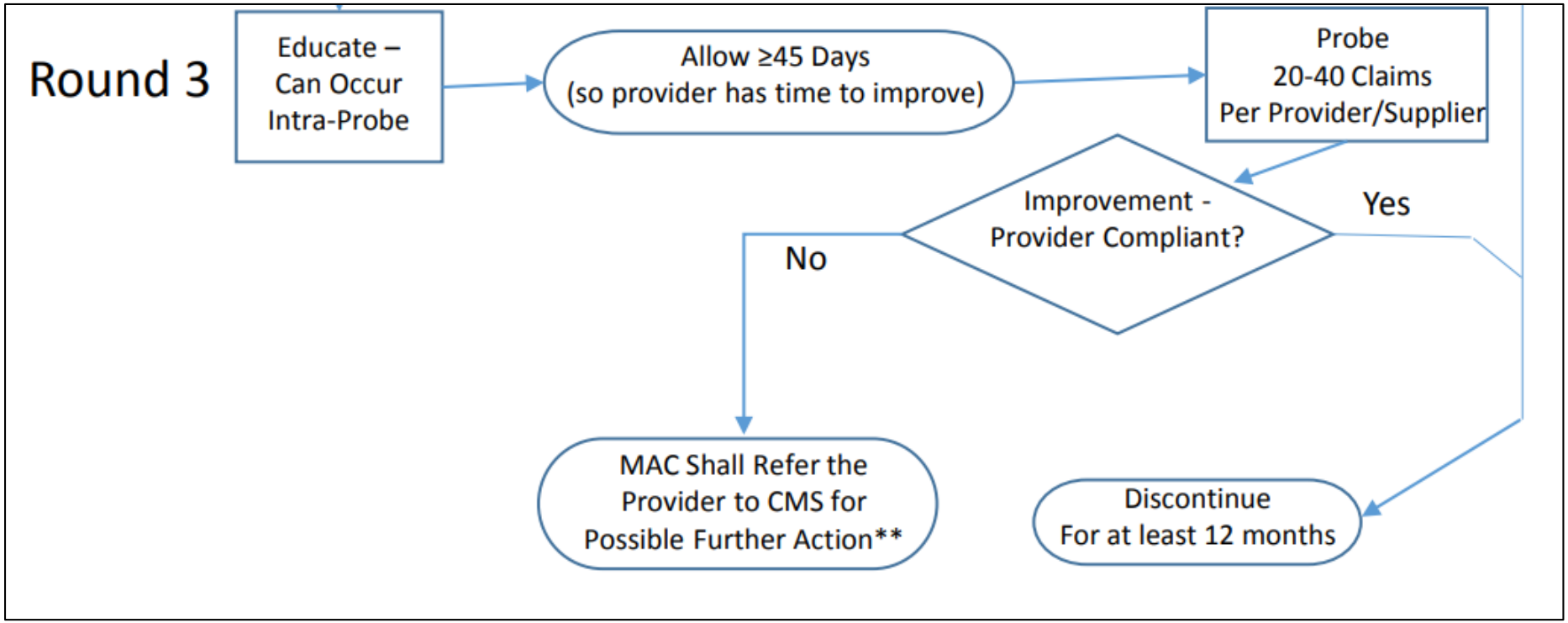
TPE Process

- MACs may conduct "related claim review" of services related to denied claim and such reviews may be conducted outside of TPE process
- TPE process does not replace or change appeal rights
  - Educational sessions not appeals forum nor do result letters and/or educational sessions extend appeal period

Targeted Probe and Educate Flow Chart



TPE Flow Chart (Continued)



Resources and References

Resources

- Patient Driven Payment Model Website
- MLN Matters® Article MM11152: Implementation of the SNF PDPM
- PDPM FAQs
- MDS Changes (ZIP) (revision posted 8-30-19)
- Fact Sheet: PDPM Patient Classification
- For questions related to PDPM policy: PDPM@cms.hhs.gov

CMS References

- CMS.gov
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
  - Chapter 8
    - SNF level of care - Section 30
    - Documentation requirements - Section 30.2.2.1
    - Services Provided on Inpatient Basis as a "Practical Matter" – Section 30.7
  - Chapter 15
  - Daily therapy requirements – Section 220

TPE References

- CMS Change Request 10249
- CMS Targeted Probe and Educate Website
- YouTube Video - Targeted Probe and Educate Medical Review Strategy
- CMS TPE Process Flow Chart

NGS Resources

- NGSMedicare.com
  - Medical Policies/LCDs
  - Medicare Topics
  - Daily Treatment Notes Requirement for Inpatient SNF Services
  - Contact Us - NGSMedicare

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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