PROVIDER COMPLIANCE TIPS FOR SKILLED NURSING FACILITY SERVICES

PROVIDER TYPES AFFECTED

Physicians, non-physician practitioners (NPPs), and providers who bill for services related to beneficiaries in Skilled Nursing Facilities (SNFs)

BACKGROUND

The Medicare Fee-For-Service (FFS) improper payment rate for SNF claims for the 2017 reporting period was 9.3 percent, accounting for 8.9 percent of the overall Medicare FFS improper payment rate.

The Medicare SNF benefit pays for certain skilled services provided in various skilled nursing settings, including swing-bed hospitals, nursing homes, and other freestanding facilities. Covered SNF services require the skills of qualified technical or professional health personnel. The SNF benefit does not cover custodial services alone, such as assistance with bathing, dressing, and using the bathroom.

REASONS FOR DENIAL

The majority of SNF service improper payments were from insufficient documentation. The primary reason for these errors was the certification/recertification statement was missing or insufficient (for example, one required element was missing). Medicare coverage of SNF services requires certification and recertification for these services.

TO PREVENT DENIALS

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine the following:

- The beneficiary requires skilled involvement for the services in question to be furnished safely and effectively.
- The services themselves are reasonable and necessary for the treatment of a resident's illness or injury. For example, the services must be consistent with:
    - The nature and severity of the individual's illness or injury
    - The individual's particular medical needs, and accepted standards of medical practice

The documentation must also show that the services are appropriate in terms of duration and quality and promote the documented therapeutic goals.

Beneficiary goals must be routinely assessed and documented to provide a sufficient basis for determining Medicare coverage. Therefore, the resident's medical record must document as appropriate:

- The history and physical exam pertinent to the resident's care (including the response or changes in behavior to previously administered skilled services)
- The skilled services provided
- The resident's response to the skilled services provided during the current visit
- The plan for future care based on the rationale of prior results
- A detailed rationale that explains the need for the skilled service in light of the resident's overall medical condition and experiences
- The complexity of the service to be performed
- Any other pertinent characteristics of the resident

The documentation in the beneficiary's medical record must be accurate and avoid vague or subjective descriptions of the resident's care that would not be sufficient to indicate the need for skilled care.

Medical records must also support the medical necessity of SNF services provided. For example, required documents include, but are not limited to:

- A certification that the beneficiary needed daily skilled care could only be provided in a SNF setting
- An authenticated plan of care
- The time (in minutes) for the therapy service provided

RESOURCES

FOR MORE INFORMATION ABOUT...	RESOURCE
Appendices Medicare Fee-For-Service 2017 Improper Payments Report	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/2017-Medicare-FFS-Payment-Data.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending
Department of Health and Human Services Agency Financial Report Fiscal Year 2017	https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf
42 CFR 424.20	https://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol3/pdf/CFR-2012-title42-vol3-sec424-20.pdf
Medicare Benefit Policy Manual - Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf