

Medicare Program Integrity Manual

Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services

Table of Contents (Rev. 721, 06-09-17)

Transmittals for Chapter 6

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

- 6.1.1 - Skilled Nursing Facility Qualifying Inpatient Stay
- 6.1.2 - Types of SNF PPS Review
- 6.1.3 - Bill Review Requirements
- 6.1.4 - Bill Review Process
- 6.1.5 - Workload

6.2 – Medical Review of Home Health Services

- 6.2.1 - Physician Certification of Patient Eligibility for the Medicare Home Health Benefit
 - 6.2.1.1 - Certification Requirements
- 6.2.2 - Physician Recertification
 - 6.2.2.1 - Recertification Elements
- 6.2.3 - The Use of the Patient’s Medical Record Documentation to Support the Home Health Certification
- 6.2.4 - Coding
- 6.2.5 - Medical Necessity of Services Provided
- 6.2.6 - Examples of Sufficient Documentation Incorporated Into a Physician’s Medical Record
- 6.2.7 - Medical Review of Home Health Demand Bills

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

6.4 – Medical Review of Rural Air Ambulance Services

- 6.4.1 – “Reasonable” Requests
- 6.4.2 – Emergency Medical Services (EMS) Protocols
- 6.4.3 – Prohibited Air Ambulance Relationships
- 6.4.4 – Reasonable and Necessary Services
- 6.4.5 – Definition of Rural Air Ambulance Services

6.5 – Medical Review of Inpatient Hospital Claims for Part A Payment

- 6.5.1 – Screening Instruments
- 6.5.2 – Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions

- 6.5.3 – DRG Validation Review
 - 6.5.4 – Review of Procedures Affecting the DRG
 - 6.5.5 – Special Review Considerations
 - 6.5.6 – Length-of-Stay Review
 - 6.5.7 – Reserved for Future Use
 - 6.5.8 – Reserved for Future Use
 - 6.5.9 – Circumvention of PPS
- 6.6 - Referrals to the Quality Improvement Organization (QIO)

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

(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)

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 (ARD) 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 PPS 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 Medical Review (MR) process are prohibited. Medicare contractors 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 Medicare 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.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>.

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 Pub. 100-02, Medicare Benefit Policy Manual, 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.

6.1.1 - Skilled Nursing Facility Qualifying Inpatient Stay

(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)

Under the SNF PPS, beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay are considered to meet the level of care requirements of 42 CFR 409.31 up to and including the assessment reference date (ARD) for the 5-day assessment prescribed in 42 CFR 413.343(b), when correctly assigned to one of the Resource Utilization Groups (RUGs) that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. If the beneficiary is not admitted (or readmitted) directly to a SNF after a qualifying hospital stay, the administrative level of care presumption does not apply. See Pub 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1 for further explanation of the administrative presumption of coverage.

Under PPS, the beneficiary must continue to meet level of care requirements as defined in 42 CFR 409.31. As noted above, 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 designated 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 ARD 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 ARD for the initial Medicare required 5-day assessment.

In the case described above, where the administrative presumption of coverage exists, Medicare contractors shall review the bill and supporting medical information specifically to confirm the correctness of the RUG assignment that triggered the presumption. This involves determining that 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, Medicare contractors shall verify that the billed RUG group is supported by the associated provider documentation. Medicare 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.

Medicare contractors shall:

- Use the Common Working File (CWF) to validate the presence of an inpatient hospital claim that was paid by Medicare. Because the entire medical record from the inpatient hospital stay is not received for a SNF claim, it is difficult to determine if the medical record and the CWF conflict. Therefore, it is assumed that the dates of service for the inpatient hospital claim in CWF are correct for purposes of establishing the 3 day prior inpatient hospital claim dates. If the CWF is silent as to an associated 3-day inpatient hospital claim, confirm that the beneficiary had a 3-day inpatient hospitalization outside the Medicare system (for example, the Veteran's Administration hospital system). If such is the case, the medical record from the inpatient hospitalization can be used to establish inpatient hospitalization dates. This documentation need not be signed for this purpose.

- Presume medical necessity of the qualifying inpatient hospitalization. If, during the normal claims review process, evidence that the hospitalization may not have been medically necessary emerges, the Medicare contractors shall fully develop the case in accordance with the directions contained in Pub. 100-02, chapter 8, § 20 and 20.1.
- Verify that the extended care services were for an ongoing condition that was also present during the prior hospital stay (even if not the main reason for that stay), or for a new condition that arose while the beneficiary was receiving treatment in the SNF for the ongoing condition. In this context, the ongoing condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay. The Medicare contractors may use a hospital discharge summary or any additional documentation from the inpatient hospital to make this verification. This documentation need not be signed for this purpose.

A beneficiary who groups into other than one of the RUGs designated as representing the required level of care on the 5-day assessment prescribed in 42 CFR 413.343(b) is not automatically classified as either meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

6.1.2 - Types of SNF PPS Review

(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)

Medicare contractors shall no longer perform random postpayment reviews specific to SNF PPS bills. Instead, SNF PPS MR should be conducted on a targeted prepayment or postpayment basis. Consider the principles of Progressive Corrective Action (PCA) when conducting MR (see Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.11 for information on PCA). Medicare 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

Medicare 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 Pub. 100-08, Medicare Program Integrity Manual, 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,

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, Medicare contractors may choose specific claims or target providers with high error rates, and must include newly participating providers.

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

B. Demand Bills

Medicare contractors 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 Pub. 100-04, Medicare Claims Processing Manual, chapter 30, section 20, and on the CMS website at www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html (see "FFS ED").

When determining eligibility for Medicare coverage, the Medicare 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 below. If the reviewer determines that no services provided were medically necessary, the Medicare 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 Medicare 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 Medicare contractor determines that coverage criteria are met (see § 6.1.3 B.), and medically necessary skilled services were provided, the Medicare 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 ARD 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 Medicare contractor requests a copy of the notice. See Pub. 100-04, Medicare Claims Processing Manual, chapter 1, §60.1.3 for further details.

6.1.3 - Bill Review Requirements

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Medicare contractors must conduct review of SNF PPS bills in accordance with these instructions and all applicable Pub 100-08, Medicare Program Integrity Manual sections, including but not limited to, Medicare contractor 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 Pub. 100-04, chapter 6, §30.1 for valid RUG codes and assessment indicators.

6.1.4 - Bill Review Process

(Rev. 656, Issued: 06-15-16, Effective: 06-28-16, Implementation: 06-28-16)

A. Obtain Records

Medicare 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. Medicare contractors are to use the MDS as part of the medical documentation used to determine whether the HIPPS codes billed were accurate and appropriate. Medicare contractors shall 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 <https://web.qiesnet.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 information below will be accurate for at least the next 5 years.

Once the clinical reviewer has used the FI Extract Tool to obtain the MDS corresponding to the period being reviewed, the reviewer will import 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 requested at MDSQC@nerdvana.fu.com. The MDS QC Tool contractor will contact CMS for approval of the request prior to sending out the MDS QC System Software and Reference Manual by FedEx.

Medicare contractors shall also request documentation to support the HIPPS code(s) billed, including notes related to the ARD, 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 ARD for each MDS marks the end of the look-back period (which may extend back 30 days), the Medicare contractor must be sure to obtain supporting documentation for up to 30 days prior to the ARD 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 Medicare contractor's Additional Documentation Request (ADR) within the prescribed time frame, the Medicare contractor shall deny the claim. See Pub. 100-08, Medicare Program Integrity Manual, chapter 3, section 3.4.1.2 for information on denials based on non-response to ADRs and section 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 Medicare contractor shall require that the provider submit the claim with the RUG code obtained from the “Grouper” software, as instructed in Pub. 100-04, Medicare Claims Processing Manual, chapter 6, § 30.1. Claims for which MDSs 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 Pub. 15-1, Provider Reimbursement Manual, chapter 28, §2833 D.1. In that specific case, Medicare 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 Medicare contractor shall deny any claim for which the associated MDS is not in the national repository.
- **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 patient's 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 RUGs designated as representing the required level of care, this creates a presumption of coverage for the period from the first day of the Medicare-covered services up to, and including, the ARD 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 ARD for the initial Medicare required 5-day assessment. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1 for further explanation of the administrative presumption of coverage.

A beneficiary who groups into other than one of the RUGs designated as representing the required level of care on the 5-day assessment prescribed in 42 CFR 413.343(b) IS NOT automatically classified as either meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures, 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 the 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 Medicare 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 current MDS QC System Software 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 current MDS QC System Software must be used to calculate appropriate payment. Medicare 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 Medicare contractor shall deny the claim in full.

Medicare contractors shall use the most current version of MDS QC System Software to review and calculate appropriate payment for SNF claims. 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 Medicare contractor has:

1. obtained the medical record and electronic MDS submitted to the state by the provider;
2. determined whether coverage criteria are met;
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 Medicare 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 Medicare 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 Medicare 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:
 - For example, when the resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) changes to such a degree that it would no longer reflect the correct RUG classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment, a PPS Unscheduled Assessment may be required to be completed. See the Resident Assessment Instrument (RAI) Manual, chapter 2, and section 2.9. The Medicare contractor shall pay the claim at the appropriate level based on the RUG code on the unscheduled PPS assessment 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,) 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 Medicare 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 Medicare 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 Medicare contractor determines (based on data entered from the medical record into the MDS QC System Software,) that
 - There is a clinical group for which the beneficiary qualifies, the Medicare 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 Medicare contractor shall deny all days.
- **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 Medicare contractor shall pay at the appropriate HIPPS code for the relevant assessment period for 8 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 OMRA as required by Medicare 8-10 days after therapy is discontinued and no other skilled care is needed, the Medicare 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 Medicare 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 Medicare contractor shall determine (based on data entered from the medical record into the current MDS QC System Software,

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 Medicare 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 Medicare 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 Medicare 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 Medicare 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.
 - If the facility RUG value obtained through the MDS QC tool **DOES NOT** match the RUG code submitted on the claim, the Medicare 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 therapy 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) 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 Medicare

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 Medicare 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 Medicare contractor shall deny the claim from the date on which the beneficiary no longer meets level of care criteria.
- 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 Medicare 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 Pub 100-08, Medicare Program Integrity Manual, 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 (Pub 100-08, Medicare Program Integrity Manual, chapter 4.)

6.1.5 - Workload

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All Medicare contractors must review some level of SNF PPS bills based on data analysis. These are *medical record 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.

6.2 - Medical Review of Home Health Services

(Rev. 603, Issued: 07-21-15, Effective: 08-11-15, Implementation: 08-11-15)

This section applies to Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Auditors and the Comprehensive Error Rate Testing (CERT) contractor.

6.2.1 - Physician Certification of Patient Eligibility for the Medicare Home Health Benefit

(Rev.603, Issued: 07-21-15, Effective: 08-11-15, Implementation: 08-11-15)

A physician certification/recertification of patient eligibility for the Medicare home health benefit is a condition for Medicare payment per sections 1814(a) and 1835(a) of the Social Security Act (the "Act"). The regulations at 42 CFR 424.22 list the requirements for eligibility certification and recertification. The requirements differ for eligibility certification and recertification; however, if the requirements for certification are not met, then claims for subsequent episodes of care, which require a recertification, will be non-covered—even if the requirements for recertification are met.

Home health agencies (HHAs) should obtain as much documentation from the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) as they deem necessary to assure themselves that the Medicare home health patient eligibility criteria for certification and recertification have been met and must be able to provide it to CMS and its review entities upon request. Per the regulations at 42 CFR 424.22(c), if the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.

Therefore, for all medical necessity reviews, the Medicare review contractors shall review the certification documentation for any episode initiated with the completion of a start-of-care Outcome and Assessment Information Set (OASIS) assessment. This means that if the subject claim is for a subsequent episode of care, the HHA must submit all certification documentation as well as recertification documentation. The review contractor shall send a documentation request to the billing HHA requesting the

supporting documentation from the certifying physician and/or the acute/post-acute care facility if the patient was directly admitted to home health from such setting (as defined in 42 CFR 424.22) that substantiates the patient's eligibility for the Medicare home health benefit.

For medical review purposes, the referring /certifying physician's initial order for home health services for a patient initiates the establishment of a plan of care as part of the certification of patient eligibility for the Medicare home health benefit. The physician's initial order must specify the medical treatment(s) to be furnished and does not eliminate the need for the plan of care as required in 42 CFR 409.43.

If the review contractor finds that the documentation in the certifying physician's medical record for that patient used as the basis for the certification of eligibility, which includes subsequent supporting documentation from the HHA (if incorporated into the certifying physician's or acute/post-acute care facility's medical record for that patient), is insufficient to demonstrate the patient is or was eligible to receive services under the Medicare home health benefit, the review contractor shall deny payment (in the case of prepayment review) or shall initiate an overpayment demand letter (in the case of post payment review).

The review contractor shall only consider a plan of care and the certification or recertification for home health services from physicians who do not have a financial relationship with the HHA. The review contractor shall only consider documentation of the face-to-face encounter from physicians or allowed non-physician practitioners, as defined in 42 CFR 424.22, who do not have a financial relationship with the HHA (see 6.2.3).

CMS does not require a specific form or format for the certification as long as a physician certifies that the five certification requirements, outlined in 42 CFR 424.22(a)(1) and section 6.2.1.1, are met.

6.2.1.1 – Certification Requirements

(Rev. 704, Issued: 03-17-17, Effective: 04-17-17, Implementation: 04-17-17)

When conducting a medical necessity review, the review contractor shall determine whether the supporting documentation addresses each of the following criteria for which a physician certified (attested to):

1. **Homebound.** Home health services are or were required because the individual is or was confined to the home per the criteria below (as defined in sections 1835(a) and 1814(a) of the Social Security Act).

- a. **Criteria-One:**

The patient must--

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

OR

- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

b. Criteria-Two:

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

In determining whether the patient meets criterion two of the homebound definition, the clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient's overall condition. The clinician is not required to include standardized phrases reflecting the patient's condition (e.g., repeating the words "taxing effort to leave the home") in the patient's chart, nor are such phrases sufficient, by themselves, to demonstrate that criterion two has been met. For example, longitudinal clinical information about the patient's health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information about the patient's overall health status may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

2. **Skilled Care.** The patient needs or needed intermittent **skilled** nursing care (other than solely venipuncture for the purposes of obtaining a blood sample), physical therapy, and/or speech language pathology services as defined in 42 CFR 409.42(c).

NOTE: Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in 42 CFR 409.42(c)), the physician must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification. The physician must sign immediately following the narrative.

3. **Plan of Care.** A plan for furnishing the services has been established and is, or will be, periodically reviewed by a physician who is a doctor of medicine,

osteopathy, or podiatric medicine (a doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law). If the physician's orders for home health services meet the requirements specified in 42 CFR 409.43 Plan of Care Requirements, this meets the requirement for establishing a plan of care as part of the certification of patient eligibility for the Medicare home health benefit.

4. **Under Physician Care.** Home health services will be or were furnished while the individual is or was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.
5. **Face-to-Face Encounter.** A face-to-face patient encounter occurred no more than 90 days prior to the home health start of care date or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by an allowed provider type defined in 42 CFR 424.22(a)(1)(v). The certifying physician must also document the date of the encounter as part of the certification.

While the face-to-face encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician, acute/post-acute care facility, and/or HHA (see below). The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., help to create a longitudinal clinical picture of the patient's health status.

6.2.2 – Physician Recertification

(Rev. 603, Issued: 07-21-15, Effective: 08-11-15, Implementation: 08-11-15)

At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. The plan of care must be reviewed and signed by the physician at least every 60 days when there is a need for continuous home care unless the beneficiary transfers to another HHA or the beneficiary is discharged and subsequently re-admitted (these situations trigger a new certification, rather than a recertification).

6.2.2.1 – Recertification Elements

(Rev. 603, Issued: 07-21-15, Effective: 08-11-15, Implementation: 08-11-15)

The contractor shall review for the certifying physician statement which must indicate the continuing need for services and estimate how much longer the services will be required.

Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode. Recertification should occur at the time

the plan of care is reviewed, and must be signed and dated by the physician who reviews the plan of care. Recertification is required at least every 60 days unless there is a—

- (i) Beneficiary elected transfer; or
- (ii) Discharge with goals met and/or no expectation of a return to home health care.

Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy. In this case reviewers will look for documentation substantiating the need for continued occupational therapy when the needed skilled nursing care or physical therapy or speech therapy that were initially needed, are no longer needed.

If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the reviewer will look for the physician's brief narrative describing the clinical justification of this need. If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

As mentioned earlier in this section, the reviewer will confirm that all elements of the certification are included in the documentation sent for the recertification claim review. If the submitted certification documentation (submitted with the recertification documentation) does not support home health eligibility, the claim associated with the recertification period will not be paid.

6.2.3 – The Use of the Patient's Medical Record Documentation to Support the Home Health Certification (Rev. 704, Issued: 03-17-17, Effective: 04-17-17, Implementation: 04-17-17)

As mentioned in section 6.2.1.1 – Certification Requirements, for home health services to be covered by Medicare, the certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain sufficient documentation of the patient's medical condition(s) to substantiate eligibility for home health services. The information may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

The physicians'/acute/post-acute care facility's medical records can always stand alone in substantiating eligibility for home health services. The physician's/acute/post-acute care facility's record, in conjunction with appropriately incorporated HHA documentation (e.g., Form 485/Plan of Care, OASIS, etc.), may also substantiate the

certification of eligibility for home health services. The HHA's generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services.

As noted earlier, per 42CFR424.22 (a) and (c) it is the patient's medical record held by the certifying physician and/or the acute/post-acute care facility that must support the patient's eligibility for home health services. Therefore, any documentation used to support certification that was generated by the home health agency must be signed off by the certifying physician and incorporated into the medical record held by the physician or the acute/post-acute care facility's medical record. **Any information provided to the certifying physician by the HHA and incorporated into the patient's medical record held by the physician or the acute/post-acute care facility's medical record (if the patient was directly admitted to home health) must corroborate the rest of the patient's medical record.** This means that the HHA information, along with the certifying physician's and/or the acute/post-acute care facility's medical record, creates a clinically consistent picture that the patient is eligible for Medicare home health services. This could include, but is not limited to, the plan of care required per 42 CFR 409.43, the initial and/or the comprehensive assessment of the patient required per 42 CFR 484.55, the inpatient discharge summary or multi-disciplinary clinical notes, etc., which must correspond to the dates of service being billed and not contradict the certifying physician's and/or the acute/post-acute care facility's own documentation or medical record entries. Once incorporated into the certifying physician's medical record for the patient, the HHA information can be used to support the patient's homebound status and need for skilled care, the reviewer shall consider all documentation from the HHA that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination. HHA documentation that is used to support the home health certification is considered to be incorporated timely when it is signed off prior to or at the time of claim submission. **See section 6.2.6 Examples of Sufficient Documentation Incorporated into a Physician's Medical Record.**

It is important to apply the review process to the entire patient's medical record that is received by the reviewer. Doing so assures that the reviewer is establishing that the HHA generated medical record documentation corroborates other patient medical records received and used to support the patient's eligibility for home health services. Therefore, the HHA generated documentation does not necessarily need to restate pertinent facts or conditions, but instead the HHA generated medical records for the patient should be in alignment with and not contradict other patient records. The HHA generated medical record for the patient together with other medical records received must lead the reviewer to confirm that the patient is eligible for home health services as established in 42 CFR 424.22(a)(1).

6.2.4 - Coding

(Rev. 603, Issued: 07-21-15, Effective: 08-11-15, Implementation: 08-11-15)

If the patient's comprehensive assessment or recertification assessment was signed off and incorporated into the certifying physician's medical record for the patient (or the acute/post-acute care facility's medical record if the patient was directly admitted to home health), contractors shall use it to determine whether the Home Health Resource Group (HHRG) codes billed were accurate and appropriate. In addition, if the comprehensive assessment is incorporated into the certifying physician's record for the patient and is used to support that the patient meets the home health eligibility criteria, then the diagnoses and conditions listed on the start of care assessment must be corroborated by information in the certifying physician's and/or the acute/post-acute care facility's own medical record documentation.

The contractor shall use the web regrouping program provided by CMS to recode claims as appropriate.

6.2.5 - Medical Necessity of Services Provided

(Rev. 603, Issued: 07-21-15, Effective: 08-11-15, Implementation: 08-11-15)

In addition to certification and recertification requirement documentation, contractors shall also review the medical record documentation to determine whether services provided were medically necessary. Again, home health generated information must be reviewed, signed off by the certifying physician and incorporated into the certifying physician medical record for the patient or the acute/post-acute care facility's medical record for the patient (if the patient was directly admitted to home health) if used to support certification/recertification.

6.2.6 - Examples of Sufficient Documentation Incorporated Into a Physician's Medical Record

(Rev. 603, Issued: 07-21-15, Effective: 08-11-15, Implementation: 08-11-15)

To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and, per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act:

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and reviewed by a physician; and
- Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP).

EXAMPLE 1:

Does the below submitted documentation support the certification statement stating that the patient meets the eligibility criteria for home health benefit certification?

Yes.

Records received by the reviewer for a HHA claim for dates of service starting on 4/15/2015:

1. Patient was admitted to the hospital with a right-sided femur fracture sustained from a fall requiring surgery. A discharge summary dated April 14, 2015, signed by the inpatient attending physician. Included in the summary was a description of the patient's injury, DME required, non-weight-bearing status, and the name of and appointment date for the community orthopedic physician who would continue to follow-up with patient, and the notation of the order for home physical therapy for home safety evaluation, gait training and strengthening 2-3 times per week for 6 weeks to be delivered by an HHA.

Meets requirements for a face-to-face encounter (occurred within the required timeframe, was performed by an allowed provider type, and related to the primary reason the patient requires home health). Identifies the need for skilled services and alludes to the fact that the patient is most likely homebound because of the non-weight-bearing status and the order for DME. Identifies physician who will be providing care while patient is receiving home health services. Plan of care established with physician orders.

2. HHA generated comprehensive assessment (admission OASIS) dated 04/15/2015 along with physical therapy progress notes. PT progress note documents patient is non-weight bearing on right leg and requires use of a two-handed device to walk alone on a level surface, and requires assistance to negotiate stairs or steps or uneven surfaces. The HHA assessment with progress notes has been signed by the community orthopedic certifying physician.

PT progress note further supports that patient is confined to the home.

3. The community orthopedic physician-signed certification statement for HH services for start of care date of April 15, 2015.

Certification statement signed by certifying physician.

4. HHA generated plan of care, which specifies the type, frequency and goals for therapies. The plan of care includes the signature of the certifying physician.

Supports that plan of care has been established and reviewed by the certifying physician.

EXAMPLE TWO:

Does the below submitted documentation support the certification statement stating that the patient meets the eligibility criteria for home health benefit certification?

Yes.

Records received by the reviewer for a HHA claim for dates of service starting on February 1, 2015:

1. Primary care physician progress note dated November 15, 2014. States reason for visit is patient has a non-healing left foot diabetic foot ulcer measuring 1 cm x 1 cm x 0.5 cm. Patient instructed on wound care with hydroactive gel dressing to be changed every 3 days. Patient able to return demonstrate application of dressing without difficulties.

Meets requirements for a face-to-face encounter (occurred within the required timeframe, was performed by an allowed provider type, and related to the primary reason the patient requires home health).

2. Clinical note in physician record states that patient called primary care physician (PCP) on January 30th stating that the wound has gotten larger and there is copious purulent drainage causing the dressing to be saturated. She states she is unable to adequately change the dressing and keep it in place because of the size of the wound and the amount of drainage. Patient just recovering from pneumonia and she says she is unable to come into the physician's office because she cannot drive. PCP made referral to HHA for skilled nursing services to evaluate the wound.

Identifies the need for skilled services.

3. HHA generated comprehensive assessment (admission OASIS) dated 02/01/2015 along with skilled nursing notes which includes wound measurements, condition of wound, and documentation of physician phone call to report findings and receipt of verbal orders for daily wound care for 3 weeks, monitor and teach on signs and symptoms of infection and initiation of oral antibiotics twice a day for 14 days. Nursing notes also states that the patient is significantly deconditioned, as a result of recent pneumonia, requires the use of a walker to ambulate from chair to bathroom with frequent stops to rest.

HHA skilled nursing notes further support that patient needs skilled services to initiate new wound care regimen, monitor for infection and that the patient is confined to the home. Physician's verbal orders for daily wound care establish the plan of care.

4. The primary care physician-signed certification statement for HH services for start of care date of February 1, 2015.

Certification statement signed by certifying physician.

5. HHA generated plan of care, which specifies the wound care orders, frequency of skilled nursing visits and goals for home health services. The plan of care includes the signature of the certifying physician.

Supports that plan of care has been established and reviewed by the certifying physician.

6.2.7 - Medical Review of Home Health Demand Bills

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

As a result of litigation settlements, A/B MACs (A) must perform *medical record reviews* 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 closest 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 for Part A Payment

(Rev. 716, Issued: 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)

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 - Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions

(Rev. 716, Issued: 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)

This section applies to Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Audit Contractors and the Comprehensive Error patient Rate Testing (CERT) contractor.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors shall conduct reviews of medical records for inpatient acute IPPS hospital, Critical Access Hospital (CAH), Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) claims, as appropriate and as so permitted by CMS, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay, and that the stay was appropriate for Medicare Part A payment.

A. Determining the Appropriateness of Part A Payment

The term “patient status review” refers to reviews conducted by Medicare contractors to determine a hospital’s compliance with Medicare requirements to bill for Medicare Part A payment. Medicare contractors shall conduct such reviews in accordance with two distinct, but related, medical review policies: a 2-midnight presumption, which helps guide contractor selection of claims for medical review, and a 2-midnight benchmark, which helps guide contractor reviews of short stay hospital claims for Part A payment. “Patient status reviews” may result in determinations that claims are not properly payable under Medicare Part A; “patient status reviews” do not involve changing a beneficiary’s status from inpatient to outpatient.

Per the **2-midnight presumption**, Medicare contractors shall presume hospital stays spanning 2 or more midnights **after** the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Medicare contractors shall not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient

admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.

Per the **2-midnight benchmark**, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights, and such reasonable expectation is supported by the medical record documentation. Medicare Part A payment is generally not appropriate for hospital stays expected to span less than 2 midnights. If a stay is not reasonably expected to span 2 or more midnights, Medicare contractors shall assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:

- If the procedure is on the Secretary's list of "inpatient only" procedures (identified through annual regulation);
- If the procedure is a CMS-identified, national exception to the 2-midnight benchmark; or
- If the admission otherwise qualifies for a case-by-case exception to the 2-midnight benchmark because the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2-midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The 2-midnight rule does not prevent such practitioners from providing any service at any hospital, regardless of the expected duration of the service. Rather, it provides a benchmark to help guide consistent Part A payment decisions.

I. Reviewing Hospital Claims for Patient Status: The 2-Midnight Benchmark

A. Determine if the stay involved an "Inpatient Only" procedure

When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor shall determine Medicare Part A payment to be appropriate if a medically necessary procedure classified by the Secretary as an "inpatient only" procedure is performed. "Inpatient only" procedures are so designated per 42 C.F.R. § 419.22(n), and are detailed in the annual Outpatient Prospective Payment System (OPPS) regulation.

Medicare contractors shall review the medical documentation and make an initial determination of whether a medically necessary inpatient only procedure is documented within the medical record. If so, and if the other requisite elements for payment are

present, then the Medicare review contractor shall deem Medicare Part A payment to be appropriate, without regard to the expected or actual length of stay. If the Medicare review contractor does not identify an inpatient only procedure during the initial review, the claim should be assessed in accordance with the 2-midnight benchmark.

B. Calculating Time Relative to the 2-Midnight Benchmark

Per the 2-midnight benchmark, Medicare contractors shall assess short stay (i.e., less than 2 midnights after formal inpatient admission) hospital claims for their appropriateness for Part A payment. Generally, hospital claims are payable under Part A if the contractor identifies information in the medical record supporting a reasonable expectation on the part of the admitting practitioner at the time of admission that the beneficiary would require a hospital stay that crossed at least two midnights.

Medicare review contractor reviews shall assess the information available at the time of the original physician/practitioners' decision. The expectation for sufficient documentation is well rooted in good medical practice. Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner's standard medical documentation, such as his or her plan of care, treatment orders, and progress notes. Medicare contractors shall consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay. These complex medical factors may include, but are not limited to, the beneficiary's medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.

For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning 2 or more midnights at the time of admission, the Medicare contractors shall take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission. This pre-admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area. If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the 2-midnight benchmark at the recipient hospital, the Medicare contractors shall take into account the time and treatment provided to the beneficiary at the initial hospital. That is, the start clock for transfers begins when the care begins in the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor shall request documentation that was authored by the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving hospital care. Medicare contractors will generally expect this information to be provided by the recipient hospital seeking Part A payment.

Medicare contractors shall continue to follow CMS' longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors shall exclude extensive delays in the provision of medically necessary care from the 2-midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary's health, Medicare contractors shall consider them in determining whether Part A payment is appropriate for an inpatient admission.

NOTE: While, as discussed above, the time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, such time does not qualify as inpatient time. (See Pub. 100-02, Ch. 1, Section 10.2 for additional information regarding the formal order for inpatient admission.)

C. Unforeseen Circumstances Interrupting Reasonable Expectation

The 2-midnight benchmark is based on the **expectation** at the time of admission that medically necessary hospital care will span 2 or more midnights. Medicare contractors shall, during the course of their review, assess the reasonableness of such expectations. In the event that a stay does not span 2 or more midnights, Medicare contractors shall look to see if there was an intervening event that nonetheless supports the reasonableness of the physician/practitioner's original judgment. An event that interrupts an otherwise reasonable expectation that a beneficiary's stay will span 2 or more midnights is commonly referred to by CMS and its contractors as an unforeseen circumstance. Such events must be documented in the medical record, and may include, but are not limited to, unexpected: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.

D. Stays Expected to Span Less than 2 Midnights

When a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under 42 C.F.R. § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for less than 2 midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the beneficiary used a bed.

The Medicare review contractor shall assess such claims to see if they qualify for a general or case-by-case exception to this generalized instruction, which would make the claim appropriate for Medicare Part A payment, assuming all other requirements are met.

E. Exceptions to the 2-Midnight Rule

1. Medicare's Inpatient-Only List

As discussed above, inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for Part A payment regardless of expected or actual length of stay.

2. Nationally-Identified Rare & Unusual Exceptions to the 2-Midnight Rule

If a general exception to the 2-midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor shall consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met.

CMS has identified the following national or general exception to the 2-midnight rule:

Mechanical Ventilation Initiated During Present Visit

CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than 2 midnights, and to embody the same characteristics as those procedures included in Medicare's inpatient-only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require 2 or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.

3. Physician-Identified Case-by-Case Exceptions to the 2-Midnight Rule

For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors shall consider, when assessing the physician's decision, complex medical factors including, but not limited to:

- The beneficiary history and comorbidities;
- The severity of signs and symptoms;
- Current medical needs; and
- The risk of an adverse event.

Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark, and as such, may be prioritized for medical review.

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

Medicare contractors shall 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 or ICD-10-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, at the time of admission, have an expected length of stay of 2 or more midnights, or otherwise meet CMS standards for payment of an inpatient admission, but that the beneficiary's condition changed during the stay and Part A payment became appropriate, 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 meet the requirements for Part A payment at any time during the admission, deny the claim in full.

6.5.3 - DRG Validation Review

(Rev. 608, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

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 coding to perform the DRG validation functions. The validation is to verify the accuracy of the hospital's ICD 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 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 Coding Manual. Contractors shall use the ICD 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 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 Manual volumes based on official ICD 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 code 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 "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, Chapter 1, §10 for further detail on payment of inpatient claims containing non-covered services.

6.5.5 – Special Review Considerations

(Rev. 608, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

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 diagnosis codes. A/B MACs (A) may wish to consider including these diagnoses in their data analysis.

For a listing of diagnosis codes identified as “questionable admission” codes see the Medicare Code Editor (MCE) Web site at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/01_overview.asp

Refer to 100-04, chapter 3, §20.2.1, subsection D.9 for a description of diagnoses which are acceptable only when coded with a secondary diagnosis. A/B MACs (A) 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 diagnosis codes that are acceptable only when coded with a secondary diagnosis see the MCE Website at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY_14_Definition_of_Medicare_Code_Edits_V_31_Manual.pdf

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 lengthly 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. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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 ZPIC/*UPIC*. 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 *medical record 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 *medical record review* of a provider's medical documentation.

If during the *medical record 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 *medical record 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#
<u>R721PI</u>	06/09/2017	Elimination of Routine Reviews Including Documentation Compliance Reviews and Instituting Three Medical Reviews	07/11/2017	9809
<u>R716PI</u>	05/12/2017	Clarifying Medical Review of Hospital Claims for Part A Payment	06/13/2017	10080
<u>R704PI</u>	03/17/2017	Home Health (HH) Language in Pub. 100-8	04/17/2017	10006
<u>R656PI</u>	06/15/2016	Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills	06/28/2016	9571
<u>R651PI</u>	05/27/2016	Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills – Rescinded and replaced by Transmittal 656	06/28/2016	9571
<u>R608PI</u>	08/14/2015	Update to Pub. 100-08 to Provide Language-Only Changes for Updating ICD-10 and ASC X12	09/14/2015	8747
<u>R603PI</u>	07/21/2015	Medical Review of Home Health Services	08/11/2015	9189
<u>R602PI</u>	07/10/2015	Medical Review of Home Health Services – Rescinded and replaced by Transmittal 603	08/11/2015	9189
<u>R601PI</u>	07/02/2015	Review of Home Health Claims	08/03/2015	9240
<u>R475PI</u>	07/19/2013	PIM Chapter 6 MR Guidelines 6.54-6.5.7 Update	08/19/2013	8379
<u>R308PI</u>	10/30/2009	Rural Air Ambulance	11/30/2009	6682
<u>R264PI</u>	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849
<u>R196PI</u>	03/30/2007	Medical Review of Skilled Nursing Facility (SNF) Claims Using the MDS QC System Software	04/30/2007	5418
<u>R174PI</u>	11/17/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
<u>R171PI</u>	11/03/2006	Transition of Medical Review Educational Activities – Replaced by Transmittal 174	10/06/2006	5275
<u>R163PI</u>	09/29/2006	Transition of Medical Review Educational Activities – Replaced by Transmittal 170	10/06/2006	5275
<u>R102PI</u>	02/01/2005	Medical Review of Rural Air Ambulance Services	02/14/2005	3571
<u>R093PI</u>	01/14/2005	Medical Review of Rural Air Ambulance Services - Replaced by Transmittal 102	02/14/2005	3571

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R082PI</u>	07/23/2004	Home Health Demand Bills	08/23/2004	3266
<u>R074PI</u>	04/23/2004	SNF Certification and Recertification	05/24/2004	3150
<u>R071PI</u>	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
<u>R042PI</u>	06/20/2003	Intermediary Medical Review Guidelines	07/01/2003	2720
<u>R026PIM</u>	04/27/2002	Deletes Section 1.7 Quality Issues in SNF and Referral to other Agencies	N/A	2100
<u>R023PIM</u>	03/18/2002	Revises and clarifies HHAs Certification and Plan of Care Data	05/02/2002	1981
<u>R020PIM</u>	02/21/2002	Revises Terminology used in Chap 6,sec 12 MR of Ambulance Services	04/01/2002	1974
<u>R018PIM</u>	01/17/2002	Manualizes PM A-00-08, Revises the existing SNF MR guidelines	N/A	1064
<u>R015PIM</u>	10/29/2001	MR of Partial Hospitalization Claims,	12/13/2001	1831
<u>R003PIM</u>	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292
<u>R002PIM</u>	9/15/2000	Intermediary MR Guidelines for Specific Services	NA	882
<u>R001PIM</u>	06/2000	Initial Release of Manual	NA	931

[Back to top of chapter](#)