5

Simple and Easy: Winning in PDPM Payment and Regulatory Strategies

It's Complicated: Part A Medicare Utilization Review

Part A Medicare Utilization Review: Documentation is Key

PDPM brought a new Part A payment process that requires skilled nursing facilities to use new criteria and data to establish the Medicare skilled benefit upon admission. Payment is now influenced by a very diverse elder-specific calculation from a large database on the Admission or IPA Assessment. Facilities must also now review patients during their stay to establish the continued need for skilled nursing or rehabilitation.

The new Utilization Review (UR) process is more complex than ever, and your internal policies and procedures must be compliant with the requirements outlined in the Medicare Benefit Policy Manual (MBPM), Chapter 8. Here's what you need to know.

1. ***Utilization Review Meetings:*** UR meetings now combine the eligibility criteria for coverage with the documentation in the medical record and the payment process (PDPM) data component. They are no longer about therapy, so detailed therapy notes are not needed. Facilities have the freedom to organize these meetings any way that fits their needs as long as they are scheduled regularly, well-documented, and follow the MBPM requirements. IDT members should attend or have input into the meetings and operational oversight is extremely important. Questions and discussions of coverage should be documented in meeting minutes or notes so that you are prepared in case of a later audit or request for further documentation. The minutes do not have to be lengthy but they do have to include the specifics – the services, the plan, the doctor's orders - of the case and show that you have been reviewing it as required.

2. ***Physician Documentation Policy:*** For services to be covered, they must be medically necessary and CMS has a very strict definition of the sufficient documentation required. It's very important that a physician has ordered the services and established a rationale for the need for them. Documentation includes details of the services, including intensity, frequency, duration and scope as well as signed orders and a legible signature. To retain your providership status, note that you must also attest that you agree to abide by Medicare laws, regulations, and program instructions and will not knowingly provide fraudulent information. Everything you submit for coverage must be documented in the medical record.

(continued)

Part A Medicare Utilization Review: Documentation is Key

3. ***Newly Revised Criteria:*** Make sure you review Chapter 6 of the RAI Manual for the new criteria – technical, clinical, and physician certification.

   Every Part A Medicare case must meet all the technical eligibility criteria for the entire Part A stay. They are:

   - Beneficiary is enrolled in Medicare Part A and has days available to use.
   - There has been a three-day prior qualifying hospital stay (i.e., three midnights).
   - Admission for SNF-level services is within 30 days of discharge from an acute care stay or within 30 days of discharge from a SNF level of care.

   New clinical eligibility criteria include:

   - The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
   - As a practical matter, these skilled services can only be provided in an SNF.
   - The services provided must be for a condition for which the resident was treated during the qualifying hospital stay, or that arose while the resident was in the SNF for treatment of a condition for which he or she was previously treated in a hospital.

   Lastly, payment is not made unless there is physician certification. The certification – and recertification – requirement is laid out in the RAI Manual. The physician must certify and then periodically recertify the need for extended care services in the skilled nursing facility, and validate that patient assignment to one of the upper PDPM groups is correct. Note that many auditors want to see the physical documents, the date signed, and identification of which physician or extender has signed the document.

4. ***Medicare Benefit Policy Manual Chapter 8:*** All coverage guidelines are in the MBPM manual, and the structure of the Utilization Review process relies on these guidelines. Case review continues throughout the entire billable Part A stay and documentation in the medical record must be complete and specific.

5. ***New Skilled Definitions:*** Chapter 8 of the MBPM was revised on October 4, 2019, and you must know and follow the new definitions included there, as this is the information auditors use. It's divided into sections, for example, Section 30 has the actual skilled services covered. Pay attention to the language used in the definitions of skilled care in Section 30, and include them with your documentation to connect care provided with the therapeutic goals.

6. ***Audits:*** We have noticed renewed audit activity since April 1, 2021. If you receive a request for documentation, look carefully at what they are asking for – here is where your UR minutes or notes will become valuable. We highly recommend you reference sections of the MBPM in your response to justify services and include your UR documentation. There has also been an increase in MACs reviewing services on a post-payment basis. Make sure you have an internal process in place to respond to all requests for additional documentation. We must be very careful that our documentation is specific and rich to show the skilled care the patient needs.

More in-depth detail can be found in our Part A Medicare Utilization Review webinar.