Palmetto GBA Skilled Nursing Facility (SNF) Ultra High and Very High Resource Utilization Group (RUG) Codes Transcript

Hello, my name is Lynn Kelly, Senior Provider Education Consultant at Palmetto GBA.

As a Medicare Administrative contractor for CMS, Palmetto GBA is tasked with preventing claims payment errors. Our Provider Outreach and Education department helps providers like you understand the fundamentals, significant changes and new initiatives of the Medicare program. This includes national and local policies, procedures, and issues identified through data analysis. Our goal is to create a strong Health Information Supply Chain. This helps reduce incorrect billing and payments, and at the same time ensures that your patients are receiving the correct level of care they need.

Palmetto GBA conducted data analysis of Skilled Nursing Facility billing use of the Ultra High and Very High Resource Utilization Group or RUG codes. These codes represent a high level of service, which can include both therapy and nursing services.

Beneficiaries receiving therapy services involving:

- 720 minutes of therapy per week; and
- Having at least one therapy discipline in five (5) days per week; and
- Having a second discipline at least three (3) days/week

Would be billed as an RU* Ultra High RUG code.

Beneficiaries receiving therapy services involving:

- 500 minutes of therapy per week and
- Having at least one therapy discipline five days per week

Would be billed as a RV* Very High RUG code.

The results of this data were compiled into Comparative Billing Reports, or CBRs. CBRs are reports that show providers how they rank against their peers in the state and nationally in billing for certain risk areas. Data analysis showed that in Palmetto GBA's jurisdiction, Ultra High RUG codes were billed 82.6 % and Very High RUG codes were billed 11.9% of all Skilled Nursing Facility claims for the period November 1, 2014 to October 31, 2015.

If, after future follow-up analysis, the provider's billing patterns continue to differ from other providers in the jurisdiction, Palmetto GBA may take steps, to include post-pay review, in order to better understand the variances in billing behavior and validate the appropriateness of billing patterns.

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The goals of this video are:

- To Identify where and how errors take place
- To determine if there is a process in your institution to double check for proper RUG assignments
- To ensure that all required components are included in the claim prior to submission for payment
- To reduce improper payments

Improper payments can result in overpayments as well as underpayments. To ensure your facility is being properly reimbursed for services billed, please follow the guidelines I will be discussing.

The number one denial reason for Skilled Nursing Facilities is the denial for not medically reasonable and necessary. Follow these suggested tips to avoid this denial:

- Submit dated physician's orders for all services billed, including services provided during all applicable look back periods
- Orders for services rendered during the look back period, written prior to the look back period, must be submitted with the documentation
- Include any separate forms used for documentation of therapy minutes
- Documentation should include the beneficiary's functional level and mental status
- Documentation in the form of checklists must include documentation of the beneficiary's response to the services rendered

Follow these therapy-specific tips to avoid the denial for not meeting the Medicare medical necessity requirements:

- The initial therapy evaluation must be performed in the Skilled Nursing Facility
- Minutes recorded on the Minimum Data Set must be the actual minutes of therapy rendered and must be supported by the therapist's documentation
- The initial therapy evaluation must reflect the resident's ability to retain instructions
- If speech-language pathology services are rendered for the treatment of dysphagia, submit all supporting documentation to establish the medical necessity of the billed services. This may include, but is not limited to, physician's notes and test results: for example, a modified barium swallow and/or a fiber-optic endoscopic examination of swallowing.
- Specific documentation related to therapy services must be submitted for review. This includes, but is not limited to, the following:
    - Physician's orders for therapy services
    - Documentation to establish that the therapy services are of a complexity that requires the skills of a licensed therapist

  - Documentation to establish the medical necessary of the therapy services as it relates to the illness/injury of the beneficiary
  - Short term and long term goals (measurable)
  - Actual minutes of therapy rendered as documented on a log/grid or in the clinical documentation
  - Progress notes and documentation of treatment modalities rendered
  - Level of function just prior to the spell of illness
  - Functional decline
  - Current level of function
  - Documentation must clearly establish that occupational therapy and physical therapy are not duplicating services

In reviewing your current processes, you need to determine whether or not your facility has a process in place to:

- Check for proper RUG code assignments
- Ensure all required components are included on each claim prior to submission
- Verify all required documentation is included in the medical record for the services billed on the claim

Each Skilled Nursing Facility should have a system in place to ensure proper RUG codes are assigned to each claim prior to submitting them claim for processing. Staff members with knowledge of Medicare documentation requirements should have access to review claims prior to submission so that potential errors and/or insufficiencies can be corrected.

If there is not a system of checks and balances in place, errors can occur. Insufficient or inconsistent documentation leads to inadequately conveyed Medical Necessity. Coding and billing errors occur resulting in delays in claim payments and ultimately improper payments or even claim denials.

We believe that if you implement these Medicare documentation recommendations into your internal processes, you will help create and maintain a strong Health Information Supply Chain. This will enable you to deliver the best care possible and avoid costly errors that could result in the loss of Medicare coverage and payment.

I’m Lynn Kelly with Palmetto GBA. Thanks for watching.