Skilled Nursing Facilities: Current Audit Issues and Potential Vulnerabilities

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While the Recovery Audit Contractors ("RACs") are currently only authorized to investigate a limited number of issues with regard to skilled nursing facilities ("SNF"), recent audits by other Medicare contractors tasked with identifying overpayments may shed light on some potential issues RACs may be identifying in the future.

At the time of this writing, the only RAC approved issues for SNF claims include consolidated billing in Region D, clinical social worker ("CSW") services in Region A, and ambulance service from SNF to SNF in Regions C and D. The consolidated billing issue in Region D requires that the majority of SNF services provided to a beneficiary under a covered Part A SNF stay are included in a bundled prospective payment, and are not billed separately. In Region A, the RACs are reviewing SNF claims to ensure that CSW providers rendering care during a SNF stay are paid under arrangement with the facility, and not billed separately under Medicare Part B. RACs for Regions B, C and D have approved a similar issue related to CSW services, but so far the issue description refers only to services rendered in inpatient hospital stays. Claims for SNF to SNF ambulance transfers, which are under review in RAC Regions C and D, are not separately payable under Medicare Part B. Rather, the SNF discharging the beneficiary is financially responsible for the cost of the transfer.

While the above-listed issues are the only SNF issues the RACs can presently review, other Medicare contractors continue to audit SNFs on a variety of issues. Ongoing audit activities by Medicare Administrative Contractors (MACs) and Program Safeguard Contractors/Zone Program Integrity Contractors (PSCs/ZPICs) highlight several areas that will likely receive increased scrutiny in the future: level of care issues, documentation, and the three-day qualifying hospital stay requirement.

Recent audits have focused on the issue of whether SNFs are billing Medicare for the appropriate level of care, based on the beneficiary's medical condition and the services to be rendered. Providers must be sure that they are appropriately documenting the beneficiary's need for skilled services – skilled nursing, physical therapy, occupational therapy, and speech/language therapy – and billing for the various disciplines only when the beneficiary's condition warrants such services.

SNFs should also focus on keeping accurate and complete records in order to justify the Resource Utilization Group ("RUG") score billed. Medicare contractors are probing SNF Minimum Data Set ("MDS") documentation, as well as the corresponding medical records for the applicable look-back periods, to determine if the provider billed the correct RUG score. It is likely only a matter of time before RACs also mark this as an area of interest.

Contractors are also devoting significant time and resources to reviewing whether a beneficiary has met the mandatory three day qualifying stay at a hospital, and was transferred to an SNF within 30 days of discharge from the hospital. While ensuring that the documentation shows the beneficiary met the three day stay and 30 day transfer requirement is relatively straightforward, it may be more difficult to demonstrate that a beneficiary had a "qualifying" stay in a hospital. To be "qualifying," the treatment that a beneficiary receives in a SNF must be for a condition for which the beneficiary was receiving inpatient hospital services, or which arose while in the SNF for treatment of such a condition. Providers should be prepared to defend audit denials on this issue. Medicare contractors have been focusing attention on this nuance, and will deny a claim if the provider cannot show that the SNF treatment is for a condition related to the hospital stay. It is also important to note that while Medicare guidance requires that the skilled services be provided for a condition for which the beneficiary received inpatient hospital care, that condition does not have to be the primary diagnosis upon hospital admission. Compliance efforts should be directed toward documenting in a manner that clearly links the skilled services provided to a condition for which the beneficiary received inpatient services, or which arose during the hospitalization or associated SNF stay.

Psychiatric admissions raise special concerns with regard to the qualifying three day stay issue. Medicare guidance states that a beneficiary with only a psychiatric condition is not eligible for Medicare coverage after being transferred from a psychiatric hospital. However, the relevant Medicare manual provision does not specifically address whether a beneficiary with a psychiatric condition can qualify for SNF services after being transferred from a non-psychiatric hospital.

SNF providers are well-advised to implement compliance measures addressing these issues not only to reduce the risk of audit by the MACs, PSCs and ZPICs, but also to reduce risk should the RACs gain approval for these issues in the future.