

WPS Medicare **Skilled Nursing Facility (SNF)** **Common Reasons for Denial**

Recent data analysis and claim review findings by the Comprehensive Error Rate Testing (CERT) contractor, as well as by WPS Medicare Part A Fiscal Intermediary/Part A MAC contractor, have identified some repetitive documentation issues among Skilled Nursing Facilities (SNFs) that are resulting in denial of SNF services upon review. The purpose of this article is to assist providers in identifying those issues and common reasons for denial, to decrease SNF claim denials, and to help reduce the paid claim error rate. Listed below are the most common reasons for denial found upon medical review of SNF documentation.

1. The documentation provided does not support that further skilled therapy services were reasonable and necessary for physical therapy (PT), occupational therapy (OT) and/or speech-language pathology (SLP).
 - a. The prior level of function (PLOF) and current level of function (CLOF) were not documented in clear, specific, objective and measurable terms to determine an actual functional decline.
 - b. The plan of care was well established and additional therapy to increase endurance, safety and monitoring does not require the skills of a therapist.
 - c. The documentation did not support skilled therapy was realistic for significant practical improvement.
 - d. The patient had a poor potential for improvement, lacked significant progress, needed frequent cueing and/or routine, repetitive services did not contain the complexity or sophistication requiring the skills of a licensed therapist. Non-skilled personnel are able to provide functional maintenance programs.
2. The documentation provided did not support services were provided as billed.
 - a. Actual therapy minutes documented in the treatment record did not equal the minutes reported on the MDS for PT, OT and/or SLP services.
 - b. Documented skilled services provided did not support the RUG-III level billed.
3. The following documentation was not received for review:
 - a. Look back documentation. The look back period is the 7, 14, or 30 day observation period used in completing sections of the MDS that require observations of a resident over specified time period. The ARD date is the common endpoint of these look back periods. When completing the MDS, only those items that occurred during the look back period will be captured. In other words, if it did not occur during the look back period, it should not be coded on the MDS. This includes intravenous (IV) medications and fluids

rendered in the acute care. The look back documentation is necessary upon medical review of a claim to ensure the appropriate RUG-III assignment was made.

- b. Initial therapy evaluation. The initial therapy evaluation is necessary to submit in all cases that therapy services are factored into the RUG assignment. The purpose of the initial therapy assessment is to establish a starting point for patient progress, identify the patient's plan of care and assess functional skills. This information is important to submit upon all reviews, regardless of the dates of service being reviewed, to monitor progress toward goals, compliance with the physician reviewed plan of care and to support that significant functional gains are being made.
- c. Therapy grids or daily service notes with the actual therapy minutes provided in each modality of service. The therapy grid or daily note is important to submit and necessary for medical review to verify that the amount of therapy captured on the MDS in section P was actually rendered, and supports the RUG-III category billed. It is important to submit the grids or daily therapy notes for all dates of service under review, as well as for any look back period associated with the review.