CLINICAL CLAIM REVIEW

Provider Insight: Skilled Nursing Facility Review

Utilization of skilled nursing facilities (SNF) has grown substantially as people live longer and the shift continues from acute care hospitals to more economical and less intensive levels of care.

The reimbursement methodology for SNF level of care can vary based on a health plan's reimbursement policies. The payer may base its policies on the amount of therapy provided or the acuity level of the resident, including diagnosis, treatments, functional status and services utilized.

Regardless of the reimbursement methodology, skilled nursing facility level of care is appropriate for short-term episodes when patients require daily professional nursing care or rehabilitation services. SNF level of care is not covered for care focused on assistance with or providing usual daily activities such as eating, bathing and dressing, and can be provided in a nursing facility by non-professional staff.

How HMS Conducts SNF Reviews

SNF Reviews validate coding accuracy and compliance with MDS requirements and CMS or health plan coverage criteria.

When HMS has been contracted by a health plan to conduct Skilled Nursing Facility Reviews, we perform retrospective reviews of SNF claims to validate coding accuracy, compliance with MDS assessment and documentation requirements, and coverage criteria in accordance with the Centers for Medicare & Medicaid (CMS) guidelines.

CMS sets the standard for reimbursement and coverage guidelines, and therefore, most payers follow CMS criteria. For those health plans with specific SNF policies that may differ from CMS, HMS will ensure reviews reflect the applicable policies.

What to Expect if You've Been Notified of an SNF Review

Claim audits are an important tool health plans use to control cost and ensure compliance with regulations and policies. When submitted claims are selected for SNF review, you will receive a medical record request letter regarding medical records relevant to the claims in question.

The medical record request will include:

- Additional information on the audit being performed
- List of medical record documentation needed in order to complete the audit
- A time frame explaining when the medical record must be received
- Instructions on the best way to submit medical record documentation to HMS

The medical record request letter you receive will include contact information for our Provider Relations team, who are ready to answer any questions and help with the audit process.

After the requested medical records are received, an experienced team of coders, nurses or physicians will perform an in-depth review of the submitted documentation. The type of audit HMS conducts on any group of claims can vary and is determined by the criteria set by the health plan.

Based on our findings, a determination is made and a notice is mailed informing you of the results. If the notice is for an overpayment, we'll provide the claim information and the rationale for the determination. It's possible you may disagree with the audit findings and rationale. Detailed instructions for appealing the determination are included.

Contact HMS today for additional questions regarding our Clinical Claims Review process or if you have questions regarding a request for medical records you received.

HMS® delivers healthcare technology, analytics and engagement solutions to help reduce costs, improve health outcomes and enhance member experiences.

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