Clinical Claim Review

Skilled Nursing Facilities

Retrospective reviews validate accuracy and ensure compliance.

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

Additionally, the reimbursement methodology for SNF level of care is based partly on the number of skilled visits utilized. This provides incentives to bill for higher number of visits than provided or were reasonable and necessary according to criteria for SNF level of care. These trends are forcing payers to take a closer look at SNF claims.

For a large health plan, HMS reviewed more than 14,000 SNF claims, and identified overpayments of over 37% of those claims—for a total savings to the plan of $16 million.

Skilled nursing facility level of care is appropriate for short-term episodes when patients require professional nursing care or rehabilitation services on a daily basis, following an inpatient hospital stay. SNF level of care is not covered for care that focuses on assisting with, or providing usual daily activities such as eating, bathing, and dressing, which can be provided in a nursing facility by non-professional staff.

Many payers reimburse SNFs according to a patient's Resource Utilization Groups (RUG) score. RUGs are mutually exclusive categories that reflect levels of resources needed in SNFs, primarily to facilitate payment. Each RUG is associated with relative weighting factors and has an assigned value that represents the amount of resources a nursing facility is expected to utilize for an individual in that group.

The RUG score is based on data elements derived from the Minimum Data Set (MDS), a mandated assessment that reflects the acuity level of the patient, including diagnoses, treatments, and an evaluation of functional status. If the assessment is not accurately completed by the provider, the RUG score will be assigned incorrectly, resulting in improper reimbursement.

HMS® performs retrospective reviews of SNF claims to validate accuracy of RUG coding, as well as compliance with MDS assessment requirements, and utilization of services in accordance with CMS guidelines. These reviews apply to all lines of business if the relevant SNF payments are driven by RUGs coding.

Advantages

- Advanced analytics target high value cases for review
- Superior quality results as demonstrated by low appeals overturn rates
- Clinical reviewers with experience with long-term care cases

Features

- Post-payment review approach
- No member liability associated with findings
- Customized to reflect your reimbursement policy and/or specific provider contract terms
- Full support for rebuttals and appeals
- Performed across all lines of business that reimburse on a prospective payment methodology: Commercial, Medicare Advantage and Managed Medicaid health plans

Potential Savings

Based upon our experience with clients nationwide, HMS projects that 22%-25% of SNF payments will have an overpayment of 12-14% of the net paid amount. With one large health plan, HMS reviewed more than 14,000 SNF claims, and identified overpayments of over 37% of those claims—for a total savings to the plan of $16 million. For another large health plan, HMS identified overpayments on 65% of the 1,700 SNF claims reviewed, resulting in $5.3 million in savings to the plan.

Contact HMS for more information about retrospective claim reviews from skilled nursing facilities.