Top Denial Reason Codes Issued by Palmetto for Part A SNF Medical Review for Alabama, Georgia and Tennessee Part A providers.

On 7/19/2018, Palmetto provided their top 5 reasons for denial of Part A SNF Services from April to June 2018. Tips to prevent these denials were included as well.

Ranked 1st – Denial Code - 5D504/5H504 – "Not Medically and Reasonable Necessary"

Make sure documentation supports a condition which arose while receiving care in a SNF or treatment in the hospital. Submit all documentation to support billed services such as a copy of the qualifying hospital stay transfer/discharge summary that relates to SNF services provided, SNF certification and recertification form, corresponding MDS assessments for each RUG code billed, all documentation used to complete each MDS assessment, physician orders for all look back periods of each MDS, separate forms for medication, wound care, staging of wounds, therapy minutes, weights, vital signs, percentage of meals consumed, bowl and bladder function, lab reports, x-ray reports, nursing or supplemental nutrition or social worker notes that support a change in condition, mental status documentation, and physician progress notes. Documentation should include a response to services rendered (i.e. care plans). Overall clinical documentation must furnish a picture of the beneficiary's care needs.

Ranked 2nd – 5DOWN – "Medical Review Downcode"

All documentation to prevent Denial Code - 5D504/5H504 is needed. Therapy specific downcode information was provided also. MDS minutes should only include the actual minutes rendered and be supported by therapy documents. Therapy evaluations must reflect the resident's ability to retain instructions. There must be an expectation of improvement within a reasonable time period. Repetitious therapy exercises are not considered skilled. Therapy is not required in situations where a beneficiary suffers a transient or easily reversible loss or reduction in function. Speech-Language Pathology services rendered for dysphagia should include supporting documents such as physician notes or test results of MBSS or FEES to support medical necessity. Therapy documents must include physician's orders and plans of care, logs/grid of therapy minutes rendered, progress notes for treatment and use of modalities. PT and OT services should not duplicate services. Therapy plans of care should document PLOF just prior to the illness, functional decline, and CLOF. A new plan of care is needed for each re-admission.

Ranked 3rd – 56900 – "Auto Denial-Requested Records Not Submitted"

Be aware of the ADR date. All records must be received within 45 days of that date. Monitor the claim status in The DDE system and gather medical records as soon as the claim goes to the location of SB6001.

Ranked 4th - 5D002/5X002 – "Agree With Provider (Bene Liable)"

ABN should be issued prior to beneficiary receiving non-covered care. Issue an ABN at termination if the beneficiary wants to continue care that is no longer medically reasonable and necessary.

Ranked 5th - 5D510- "There was no evidence of at least three consecutive day of inpatient hospital stay"

Ensure there was a qualify hospital stay of 3 consecutive days and provide documentation that supports that. Reason for hospitalization is required.

Information was obtained from the following link:

https://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/B2TLTV4282?opendocument