



PROPRIETARY STATEMENT

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Please direct all questions to HTS Compliance, who can be reached at:
compliance@htstherapy.com

Triple Check Policy and Procedure

I. Policy Statement and Purpose

The Facility is committed to ensuring billing accuracy and timeliness for allowable services. Processes that ensure coding and billing accuracy are essential in the Skilled Nursing Facility (SNF) including adherence to guidelines set forth in the Medicare Beneficiary Policy Manual, Medicare Claims Processing Manual, the Resident Assessment Instrument (RAI) 3.0 User's Manual, and per the Final Rule / Federal Register implementing the PDPM (Patient-Driven Payment Model) effective October 1, 2019. The triple check system provides an internal audit of claims prior to submission in an effort to decrease billing errors and promote continual compliance.

II. Policy

This policy applies to all pre-bill claims identified by the facility as subject to the Triple Check process. The designated interdisciplinary representatives will collaborate to ensure compliant billing through a routine review process completed prior to the release of claims to the payer for payment of services rendered.

III. Procedures

1. At minimum, a monthly triple-check process is conducted to verify that claims are accurate prior to submission to the Medicare Administrative Contractor (MAC), non-traditional Medicare payer, private insurance, or other payers designated by the facility. A weekly process may be appropriate as needed e.g. based on high volume Medicare census.
2. A routine time designated in coordination with the billing schedule shall be established to review critical elements of documentation to validate services and supplies prior to billing.
3. Interdisciplinary designees shall be assigned to participate in the routine meeting time. Attendees may include, but are not limited to the following:
 - a. Executive Director / Administrator
 - b. Business Office Representative
 - c. Director of Nursing (DON) or Nursing Representative
 - d. RAI Nurse Coordinator
 - e. Facility Rehab Designee
 - f. Medical Records
4. The triple-check process will include key items for each claim using a checklist or triple-check audit tool.
5. Each of the facility participants will complete their respective key items in advance of the meeting through review of billable services rendered for which they are responsible and validate the documentation requirements for supporting those charges are met. An example of roles includes the following:

- a. Executive Director / Administrator –
 - i. Ensure the process is completed by the facility each month prior to claims submission.
 - ii. Oversee communication effectiveness of facility processes between the interdisciplinary team members.
 - iii. Check the physician certification for accuracy and timeliness:
 - 1. timely signature
 - 2. explanation of continued skilled need and includes a brief description for all skilled services.
 - 3. estimated days requiring SNF care
 - 4. discharge plans
 - iv. Verify due date for physician initial visit (within 30 days of admission) and subsequent physician visits with corresponding progress note review.
- b. Business Office Representative –
 - i. Validate qualifying stay requirements are met
 - ii. Validate that each resident has benefit days available per the Common Working File (CWF) or via other means available based on payor
 - iii. Review UB04 Accuracy:
 - 1. Resident data: name, DOB, sex, HIC # against MCR card
 - 2. Admission date agrees with facility manual census log.
 - 3. Bill type and covered service dates are accurate
 - 4. Total number of service units corresponds with the covered service dates
 - 5. Occurrence codes correct, including MCR skip dates / LOA days
- c. Director of Nursing (DON) –
 - i. Verify the presence of daily skilled nursing clinical documentation during the dates of service (e.g. daily skilled nursing notes are present on the medical record, charting relates to the skilled service being provided, documentation supports any ordered therapy services, etc.)
 - ii. Verify that physician orders have been obtained, implemented, and signed/dated.
 - iii. Verify that all appropriate ancillary charges are reflected on UB-04 with appropriate documentation validated in the medical record. Ancillary charges may include the following:
 - 1. Surgical dressing supplies
 - 2. Prosthetic devices (catheter, colostomy supplies, etc.)
 - 3. Laboratory
 - 4. Radiology
 - 5. Pharmacy
- d. RAI Nurse Coordinator –
 - i. Validate that assessment reference dates per MDS (5-day & optional IPA) accurate to UB-04
 - ii. Validate that HIPPS code per MDS accurate to UB-04
 - iii. Validate that number of units on UB-04 corresponds with HIPPS code(s)

- iv. Verify principle diagnosis is accurate, as well as active primary designated in MDS section I0020B, and secondary diagnoses all support skilled care and all rehabilitation services, and the ICD-10-CM codes correspond to the diagnoses and sequenced appropriately.
 - v. Validate MDS transmission accepted into QIES per validation reports
 - e. Facility Rehab Designee –
 - i. Verify that rehabilitation services physician orders are present and signed/dated appropriately
 - ii. Validate physician signed/dated therapy POC/Updated POC forms
 - iii. Validate appropriate primary and treatment diagnoses are present
 - iv. Validate timely therapy progress reports are present per payor guidelines
 - v. Verify that all therapy discipline units and/or visits are accurate per the service log and correspond appropriately to the UB-04 according to payor guidelines.
 - vi. The total amount of group/concurrent minutes, combined, is < 25% of the total amount of therapy for each discipline (MCR A)
 - vii. Verify that the HCPCS code UB-04 matches the CPT performed per service log.
 - viii. Ensure documentation supports reasonable and medically necessary services appropriate based on the individual clinical needs of the patient
 - f. Medical Records
 - i. Gather all necessary medical records for the Triple Check Meeting
 - ii. Make note of any items requiring correction prior to billing
6. The checklist/audit tool will be completed during the triple-check meeting to Validate accuracy for all billable services.
 7. Any errors discovered during the triple check process should result in holding the billing of related claim(s) until such time as the error can be corrected.
 8. Once the incorrect item(s) have been corrected, the correction will be noted on the checklist/audit tool and the facility will submit the claim.

APPROVALS	PRINTED NAME	SIGNATURE	DATE
Executive Leadership			
Chief Compliance Officer			
General Counsel			
REVIEW and REVISIONS			
Version #: Date:			
Summary of changes:			
Version #: Date:			
Summary of changes:			