



PROPRIETARY STATEMENT

**NOTICE: THE INFORMATION CONTAINED WITHIN THE HTS PARTNER PORTAL
IS PROPRIETARY TO Healthcare Therapy Services (HTS), DO NOT SHARE.**

Dear Valued HTS Partner, you are authorized to receive access to use the following HTS proprietary materials. All of these documents are property of and owned by HTS. This document and any other related materials shall not be disseminated, distributed or otherwise shared with any outside organization or public platform unless written permission is obtained by HTS.

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

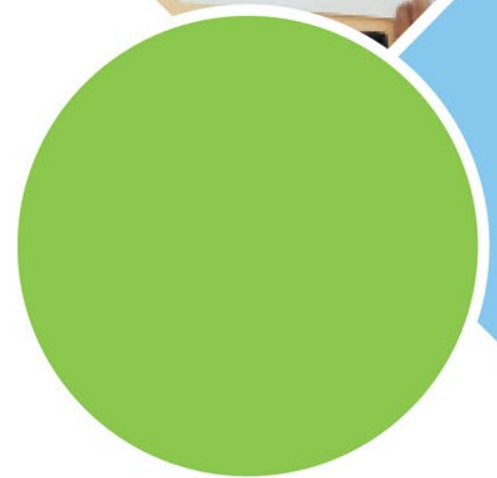


PROACTIVE

MEDICAL REVIEW

Triple Check:

Compliance Process to Ensure Coding and Billing Accuracy



Objectives

1. Review compliance standards surrounding billing and coding accuracy.
2. Understand the importance of an effective Triple Check process
3. Identify team member roles and responsibilities within the Triple Check Meeting
4. Implement operational strategies to ensure claim compliance for accurate billing and coding

Medicare Benefit
Policy Manual

Chapter 9

Medicare Claims
Processing Manual

Chapter 6

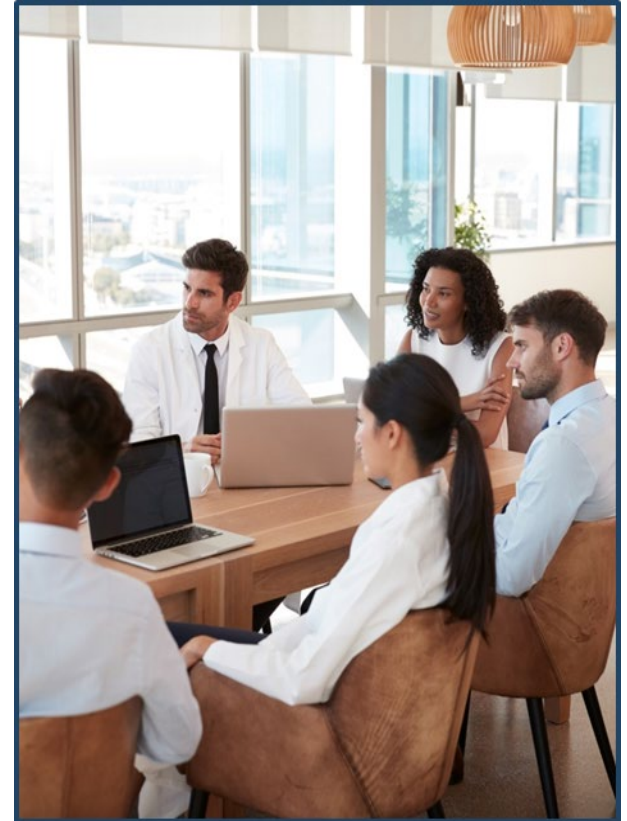
**Billing
Compliance**

Resident
Assessment
Instrument 3.0
User's Manual

Final Rule /
Federal Register

What is Triple Check?

- Internal Claims Audit
- Pre-bill claims
 - Medicare Part A Claims and other payors designated by the facility
- IDT representatives
- Routine review



Why is Triple Check Important?

- Promotes Compliance
- CMS guidance and regulations
- Payment Accuracy Initiatives
- Reduce denied, rejected, adjusted claims
- Reduce potential for medical review
- Prevent submission of false claims
- Appropriate report of facility data
- Accurate billing for services provided

Triple Check Team

Business
Office

MDS
Department

Rehab
Department

Clinical
DNS/ADNS

Administrator
/ Executive
Director

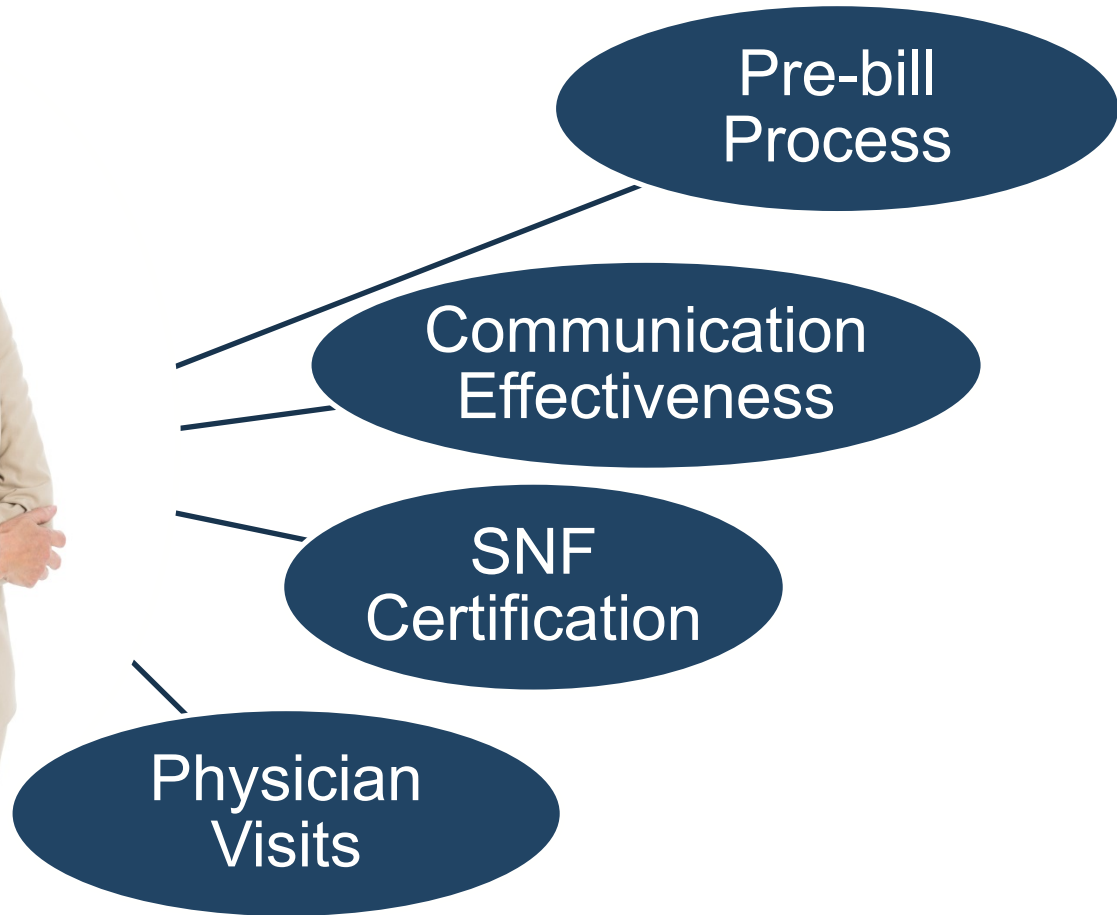


Medical Record Review

1. UB-04 (draft claims)
2. ICD-10 Diagnosis List
3. MDS Assessment(s)
4. Medical Record
 - Hospital documentation
 - SNF Certification / Recertification
 - Physician Documentation
 - Nursing Documentation
 - Therapy Documentation



Administrator / Executive Director



Business Office Representative

- Validate qualifying stay requirements are met
- Validate that each resident has benefit days available per the Common Working File (CWF) or via other means available based on payor
- Review UB04 Accuracy:
 - Resident data: name, DOB, sex, HIC # against MCR card
 - Admission date agrees with facility manual census log.
 - Bill type and covered service dates are accurate
 - Total number of service units corresponds with covered service dates
 - Occurrence codes correct, including MCR skip dates / LOA days

Director of Nursing Services

- 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.*
- Verify that physician orders have been obtained, implemented, and signed/dated.
- Verify that all appropriate ancillary charges are reflected on UB-04 with appropriate documentation validated in the medical record.
 - *e.g. Surgical dressing supplies, Prosthetic devices (catheter, colostomy supplies, etc.), Laboratory, Radiology, Pharmacy*

RAI Nurse Representative

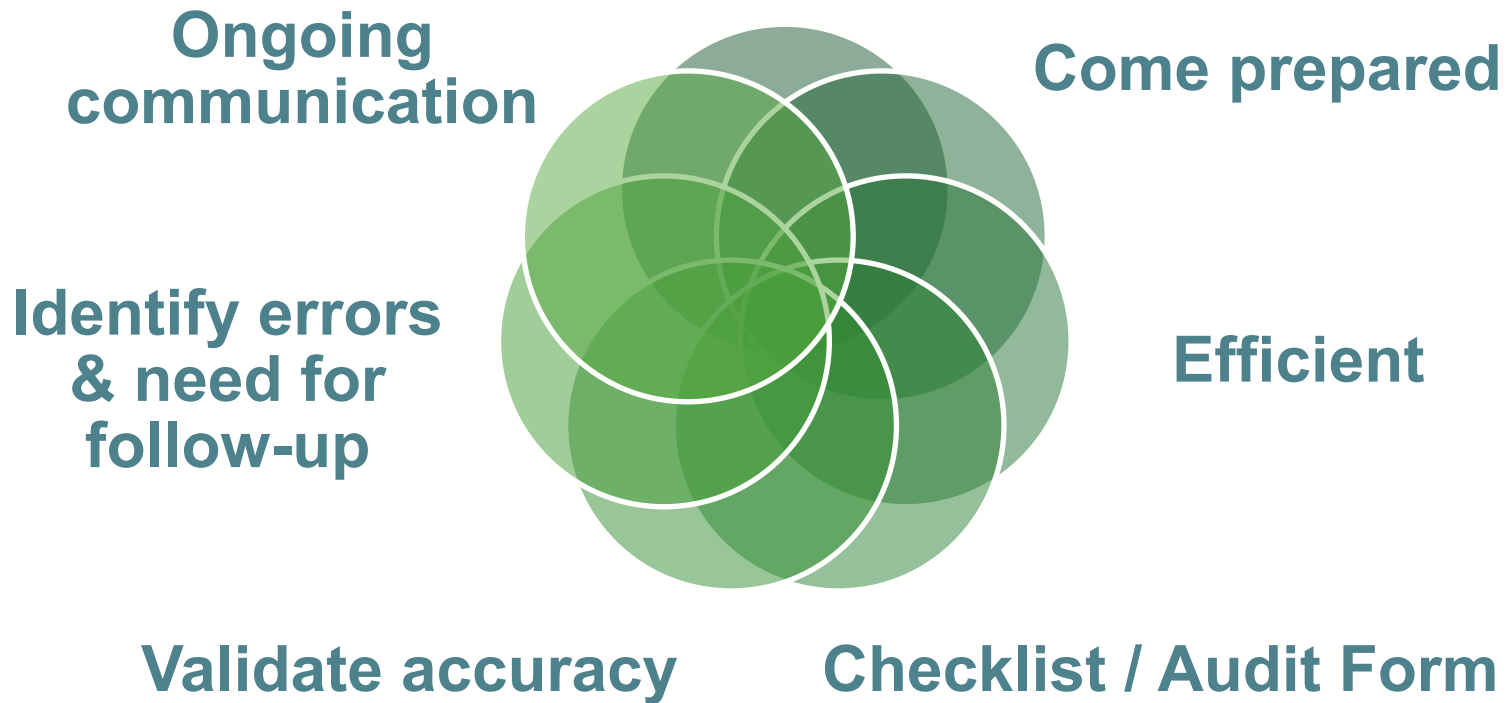
- Validate that assessment reference dates per MDS (5-day & optional IPA) accurate to UB-04
- Validate HIPPS code per MDS is accurate to UB-04
- Validate number of units on UB-04 corresponds with HIPPS code(s)
- Verify principle diagnosis is accurate, as well as active primary designated in MDS section 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.
- Validate MDS transmission accepted into QIES per validation reports

Therapy Representative

- Verify that rehabilitation services physician orders are present and signed/dated appropriately
- Validate physician signed/dated therapy POC/Updated POC forms (30 days)
- Validate appropriate primary and treatment diagnoses are present
- Validate timely therapy progress reports are present per payor guidelines
- 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.
- The total amount of group/concurrent minutes, combined, is < 25% of the total amount of therapy for each discipline (MCR A)
- Verify that the HCPCS code UB-04 matches the CPT and number of units performed per service log (Medicare part B)
- Ensure documentation supports reasonable and medically necessary services appropriate based on the individual clinical needs of the patient

Triple Check Process

Routine Meeting Time



Clean Claim Checklist Items

Patient Name

Business Office

Verify resident name, DOB, sex, HIC # against MCR card and CWF

Verify the qualifying hospital stay

Verify co-insurance days

Verify admission/re-admission date

Verify census days/room and board to UB-04 billed days (review LOA)

Verify benefit days available per Common Working File (CWF)

Check for Medicare Secondary Payer (MSP)

Executive Director / Administrator

MD completed & signed SNF cert within 72 hours of admission

SNF recertification(s) signed a minimum of every 30 days with brief description for all skilled services, as well as noted estimated time requiring skilled care, along with discharge plans

Verify due date for physician initial (within 30 days of admit) and subsequent visits with progress note review.

DON or Nursing Designee

All physician orders are signed and dated in a timely manner

Verify that physician orders have been obtained and implemented.

Verify daily skilled clinical documentation during the dates of service.

Nursing notes justify skilled need for full duration (skilled nursing, rehab nursing procedures, skilled care planning, teaching, etc.)

Significant change supporting rehab SOC is clear; PLOF documented objectively for therapy goal areas outside of therapy records

Admission assessment is completed within 24 hours of admission

Verify that all appropriate ancillary charges are reflected on UB-04 with appropriate documentation validated in the medical record. (ie. Surgical dressings, prosthetic devices (catheter, colostomy supplies, etc, laboratory, radiology, pharmacy, etc)

Is care plan up to date, reflect skilled nursing management, signed

RAI Nurse	HIPPS Code			
Primary reason for skilled stay ICD10CM appropriately represented in MDS I0020B				
ICD-10-CM codes are accurate and correctly sequenced on the UB04, primary dx matches facility & coordinates with hospital/rehab dx, any surgical hx relates to primary skilled need				
ARDs per each MDS (5-day & optional IPA) accurate to UB-04				
HIPPS code(s) accurate to UB-04 and documentation supports each component				
PT/OT Payment Group				
SLP Payment Group				
NTA Payment Group				
Nursing Payment Group				
Number of units on UB-04 corresponds with assessment type				
Confirm MDS verified/ signed timely by relevant disciplines				
Timely MDS completion <i>Z0500B date ≤ 14 days from ARD A2300</i>				
Timely MDS transmission <i>Z0500B date $\leq + 14$ days</i>				
MDS transmission accepted into QIES per validation reports				
Care plan supports MDS, skilled service (teaching, condition changes)				
Therapy				
Rehab supported with weekly justification of medically necessity based on clinical needs full duration				
Rehabilitation services are stated on physician orders, and signed/dated appropriately				
Physician/NPP signed & dated therapy POC/UPOC forms timely				
Primary and treatment diagnoses are present				
Timely therapy progress reports are present per payer guidelines				
Rehab mins/days accurate MDS for each assessment period compared to therapy logs per payer guidelines (ie. Managed Care).				
The total amount of group/concurrent minutes, combined, is < 25% of the total amount of therapy for each discipline (MCR A)				
Therapy units/mins/HIPPS/ARD match on UB-04, MDS, & rehab doc				

5-character HIPPS code

- Character 1: PT/OT Payment Group
- Character 2: SLP Payment Group
- Character 3: Nursing Payment Group
- Character 4: NTA Payment Group
- Character 5: Assessment Indicator

HIPPS Coding Crosswalk

OT/PT CMG	SLP CMG	NTA CMG	HIPPS Character
TA	SA	NA	A
TB	SB	NB	B
TC	SC	NC	C
TD	SD	ND	D
TE	SE	NE	E
TF	SF	NF	F
TG	SG		G
TH	SH		H
TI	SI		I
TJ	SJ		J
TK	SK		K
TL	SL		L
TM			M
TN			N
TO			O
TP			P

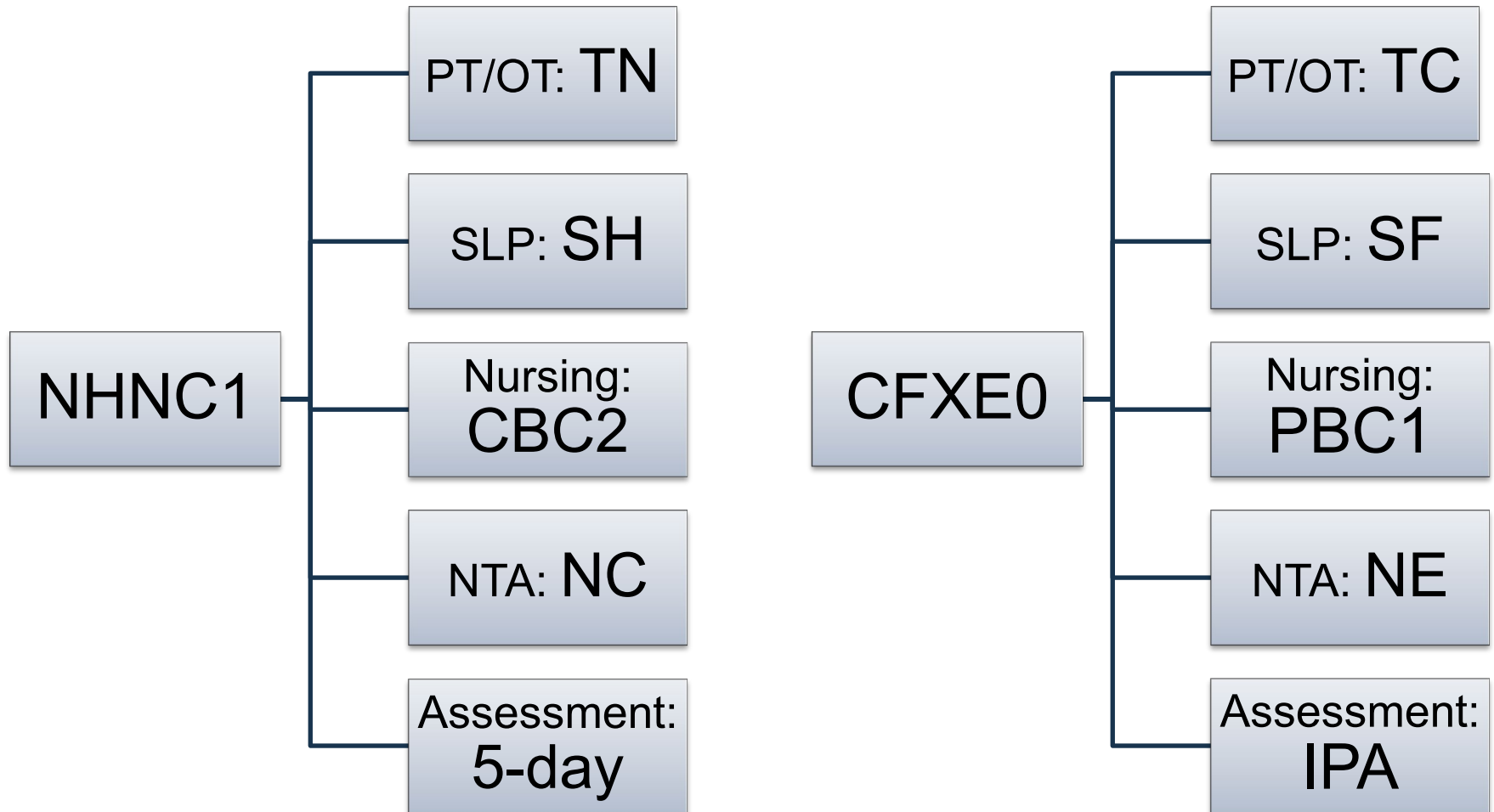
HIPPS Code Crosswalk

Nursing CMG	HIPPS Character	Nursing CMG	HIPPS Character
ES3	A	CBC2	N
ES2	B	CA2	O
ES1	C	CBC1	P
HDE2	D	CA1	Q
HDE1	E	BAB2	R
HBC2	F	BAB1	S
HBC1	G	PDE2	T
LDE2	H	PDE1	U
LDE1	I	PBC2	V
LBC2	J	PA2	W
LBC1	K	PBC1	X
CDE2	L	PA1	Y
CDE1	M		

HIPPS Code Crosswalk

Assessment Type	HIPPS Character
IPA	0
PPS – 5 Day	1
OBRA Assessment (not coded as a PPS Assessment)	6

HIPPS Coding Examples



5 Character HIPPS Code Example (CFXE0)

Character	Component	HIPPS Code Explanation
1	PT/OT Payment	<i>C – (TC) Major Joint Replacement or Spinal Surgery. Function Score 10-23. Documentation must validate primary reason for SNF stay ICD10 code appropriate and was a condition treated during the hospital stay. Function score must be supported within the documentation as usual performance during first 3 days of admission.</i>
2	SLP Payment	<i>F – (SF) Documentation must support any one of the following: Acute Neurologic Condition, SLP-related Comorbidity, or Cognitive Impairment. Must also validate supporting documentation for both swallow impairment and a mechanically altered diet.</i>
3	Nursing Payment	<i>X – (PBC1) Documentation must support nursing category Reduced Physical Function which might include behavioral symptoms and cognitive performance with NFS <11, or the patient might present with other conditions not specified in other nursing categories. The nursing function score for 6-14 must also be validated as usual performance.</i>
4	NTA Payment	<i>E – (NE) Documentation must support presence of certain comorbidities or use of certain extensive services which total NTA score range 1-2.</i>
5	AI	<i>0 – (IPA) Documentation must demonstrate we are following our facility policy for completing the IPA. This might require documentation to support a change in the clinical condition that is the primary reason for the SNF stay, a major change in function score, or some other substantive change in one of the variable which impact the component case mix rate.</i>

PDPM Default Billing

- Default HIPPS Code: ZZZZZ
- Default rate refers to lowest possible per diem rate
- Equivalent to billing:
 - PT – TP (1.08)
 - OT – TP (1.09)
 - SLP – SA (0.68)
 - Nursing – PA1 (0.66)
 - NTA - NF (0.72)

Key Compliance Risks

- Physician SNF Certification
- Accurate Capture of Resident Case Mix Groups
- Mechanically Altered Diets
- Therapy Intensity determined by clinical needs of the patient
- Over use of IPA
- Over use of Interrupted Stay Policy
- Billing for services not provided or rendered as claimed



Common Errors



- Billing for service prior verifying accurate HIPPS code
- Inaccurate primary SNF condition identified as extension of acute stay
- Conditions coded without active service need (ie. SLP comorbidity)
- ICD10 codes not included in MDS Section I as secondary conditions
- Documentation to support swallow impairment
- Proof of sufficient of physician oversight

Triple Check Compliance Teamwork





PROACTIVE

MEDICAL REVIEW



Triple
Check

proactivemedicalreview.com

*Proactive partners with providers for regulatory compliance,
training, and medical review solutions.*

©2019 Proactive Medical Review & Consultants, LLC, may be used with permission by current affiliates.

Resources

Medicare Benefit Policy Manual Ch. 8

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf>

Medicare Claims Processing Manual Ch. 6

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf>

Center for Medicare and Medicaid Services. (2019). MDS 3.0 RAI Manual.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

SNF PPS FY2019 Final Rule

<https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf>

Centers for Medicare and Medicaid Services. (2019). Patient Driven Payment Model.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>

ICD.10-CM Clinical Category Mapping:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>

PDPM Triple Check Meeting Sample Video



Video

Click here to watch the video! <https://youtu.be/d4V27zG4drY>