PROPRIETARY STATEMENT

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PROACTIVE MEDICAL REVIEW

Competency Based Training & Assessment
Made Easy!

Triple Check Basics

This Tool-kit is intended to assist facilities in establishing and/or updating processes that promote continual compliance to ensure coding and billing accuracy essential in the Skilled Nursing Facility (SNF).

Toolkit Introduction & Overview

Skilled nursing facilities (SNF) must ensure Medicare coding and billing accuracy prior to submission of claims. The Patient Driven Payment Model effective October 1, 2019 significantly changes the factors impacting reimbursement during the SNF stay, expanding the number of Minimum Data Set (MDS) Assessment items impacting payment and updating HIPPS coding. This tool kit is intended to assist facilities in establishing and/or updating existing processes to promote clean claims for accurate billing.

Tool-Kit Table of Contents

How to Use These Tools

This tool kit including training materials may be reviewed based on facility policy, but is generally recommended for review with applicable employees upon hire, annually, and as needed when gaps in competency are identified. This tool kit includes post-tests that can be used to evaluate subject matter knowledge and competency evaluation forms to validate skill in the Triple Check Meeting process

Practical Applications

This tool kit can be utilized to prepare Triple Check team members for an effective and compliant process in “clean claims” submission, or accurate pre-bill review. Consider your process for identifying gaps in competency related to compliance & ethics surrounding accurate billing and coding practices. This tool kit focuses on basic compliance risks associated with billing and reimbursement and validating supporting documentation meeting SNF regulatory requirements for billing traditional Medicare services. Use of an audit tool will assist in submitting claims only for services that are clearly supported by the medical record. The process may be utilized to identify Performance Improvement action plans implemented by the Quality Assurance Performance Improvement (QAPI) team as well.

This Tool Kit may be used with permission of Proactive Medical Review by a single purchasing facility and documents may be edited to customize based on this single purchasing facility’s needs.

Lesson Plans & Instructor Guide for use with PowerPoint™ Presentation

Presentation Format Timing

Present the material using the power point slides and resources based on your facility needs. Suggested training format:

- Orientation/Annual Training/Remediation: Use the power point slides and instructor guidance below to train staff. Assess competencies through use of the post tests and Competency Evaluation forms.

The suggested timing for each part of the training session is:

Powerpoint Training + Activities	Time
Introduction of Instructor, Topic, & Objectives	*5 minutes*
Interactive Lecture with Power Point and Case Studies	*30 minutes*
HIPPS Coding Practice	*10 minutes*
Question & Answer	*5 minutes*
Post-Test	*5 minutes*
	Total: 55 minutes

Interactive Lecture

With this method you present the material, using questions-and-answers and the provided PowerPoint™ slides. During your lecture, be sure to personalize the presentation as much as possible. Discuss scenarios that have occurred and provide examples of difficult to navigate compliance billing and coding situations that administrative staff may have encountered in your company.

Update the PowerPoint presentation for annual training to fit your company's specific needs. It is encouraged to review the PowerPoint to ensure it is company specific.

See below for slide specific company individualization ideas:

Slide 2:
The purpose of this training session is to review our facility's process to ensure coding and billing accuracy. This is known as the Triple Check process. Specifically we will cover (read slide).

Slide 3:
Our facility is committed to ensuring billing accuracy and timeliness for allowable services. We must include processes that ensure coding and billing accuracy. Primary drivers for billing compliance include Skilled Nursing Facility (SNF) regulations including adherence to guidelines set forth in Chapter 8 of the Medicare Beneficiary Policy Manual, Chapter 6 of Medicare Claims Processing Manual, the RAI User's Manual for proper coding of the MDS assessment, and the Final Rule / Federal Register implementing the PDPM (Patient-Driven Payment Model) effective October 1, 2019.

Slide 4:
The triple check system provides an internal audit of claims prior to submission in an effort to decrease billing errors and promote continual compliance for our facility billing practices. This system applies to pre-bill claims including Medicare Part A, (insert additional payor type claim review expected).

Slide 5:
The Triple Check process plays a vital role in our facility's compliance program; particularly in the auditing and monitoring piece. We must take every step necessary to ensure we submit "clean" claims – meaning accurate claims. Through our triple check process we can reduce the number of denied, rejected, or adjusted claims. And we can prevent the occurrence of false claims. Again, we want our billing data to accurately reflect the services provided.

Slide 6:
A minimum team of 3 interdisciplinary members is required to complete the Triple Check process. We have assigned a member from the business office, the MDS department, and the therapy department. With the transition to PDPM the amount of information to review for billing accuracy has increased, so as a best practice we also include the facility Executive Director as well as the Director of Nursing Services to serve as a clinical team member. Each of the facility participants will complete their respective key assignments in advance of the meeting. The members are responsible for validating documentation and requirements for billing services. We will take time to review the specific assignments during this training.

Slide 7:
The UB-04 is the foundation of the triple check review. It is important that we review draft claims prior to billing. The UB-04 must accurately reflect the care and services provided to our patients during the period identified on the claim, which is typically in the prior month. It is our responsibility to ensure the claim is an accurate reflection of the medical record and care provided. So a thorough review of physician documentation including hospital records, SNF certification / recertification, physician orders and progress reports, and MDS assessments with supporting documentation from nursing and therapy is vital. Again, this process is important to assure each claim is error free and reflects the care delivered to the patient..

Slide 8:
Let's take some time to review responsibilities for each team member.
"Our administrator has oversight and ensures our process is completed each month prior to claims submission. He/she oversees our communication effectiveness and processes between the team members.
He/she will also validate the SNF physician certification for accuracy and timeliness related to the signature / date, appropriate explanation of continued skilled need with brief description for all skilled services, estimate days requiring SNF care, as well as discharge plans.
He / she will also verify the date for the physician initial visit (within 30 days of admission and any necessary subsequent visits with corresponding progress note review."

Slide 9:
The business office representative is responsible to (read slide).
The business office will also manage the audit tool that we will discuss later.

Slide 10:
Our clinical team member is the Director of Nursing Services. This team member is responsible for (read slide).

Slide 11:
The MDS nurse representative will be responsible for (read slide).

Slide 12:
The therapist representative will be responsible for (read slide).

Slide 13:
Now that we understand the roles and responsibilities, let's review our facility process.
A routine time designated in coordination with the billing schedule has been established to review critical elements of documentation to validate services and supplies prior to billing. At minimum, we include a monthly triple-check process to verify that claims are accurate prior to submission to the Medicare Administrative Contractor (MAC). Non-traditional Medicare payer, private insurance, or other payors designated by the facility may be included in the process as well.
As the team identifies gaps in documentation / criteria to support the claim meeting SNF regulatory requirements, an assigned team representative will be responsible to follow-up and assure the components are met for claim accuracy. The team will have ongoing communication until all claims are appropriate to release for billed services.

Slide 14:
Here, we can see our Triple Check tool, or Clean Claims Checklist Items. Each of the team member responsibilities are listed as tasks to complete prior to the meeting for each of the patients with a draft UB04. The representative from the business office will identify the patient name for review in each column on the meeting date. In this example, the check mark indicates the documentation review supports billing. The circled items indicate missing documentation. For example, the missing SNF certification will require follow-up to ensure the form is returned from the physician office, or perhaps there is need for a delayed certification form. We can also see that there were some missed physician signature / dates on orders for another patient, as well as missing documentation to support ancillary charges on a separate patient review.

Slide 15:
This slide includes the portion of the audit tool to be reviewed by the MDS representative and therapist representative. You will notice here the need to validate the HIPPS code on the UB04. Let's go ahead and take a deeper look at HIPPS code mapping for payment classification under PDPM.

Slide 16:
Traditional Medicare part A Claim periods beginning 10/1/19 will include a 5 character HIPPS code applied to the UB04. The first character will represent the OT/PT payment group, the second character will represent the SLP payment group, the third character will identify the nursing payment group, the forth character will relate to the NTA payment group, and the fifth will be related to the assessment indicator (AI).

Slide 17:
On the next 2 slides we will take a look at the HIPPS Coding Crosswalk. This particular slide reflects the HIPPS character for the case mix groups (CMG) related to the OT/PT category, SLP category, and the Non-therapy ancillary (NTA) category. As you can see, a the CMG "TF" for will map to the HIPPS character "F." Likewise, the CMG "SF" for SLP category, and the CMG "NF" for the NTA category will map to the HIPPS character "F."

Slide 18:
This slide shows us the HIPPS code crosswalk specific to the PDPM nursing category.
As an example, the HIPPS character "E" would identify payment for Nursing case mix group HDE1, and the HIPPS character "V" would identify payment for nursing case mix group PBC2.

Slide 19:
And finally we have the crosswalk for the 5th character which is identified for by a number. The IPA assessment type will correspond with HIPPS character "0," the PPS 5 day assessment will correspond with HIPPS character "1," and OBRA assessments correspond with HIPPS Character "6."

Slide 20:
(use HIPPS Coding Crosswalk Tool for this slide)
"Here we see an example of how an actual HIPPS code might appear on the UB04 for payment.
First, let's look at the NHNC1. We can use our HIPPS Coding Crosswalk Table to assist us in identifying if this payment classification is accurate. The first character "N" associates with the OT/PT clinical category for Non-Orthopedic Surgery and Acute Neurologic, with a function score of 6-9. The "H" corresponds to the SLP CMG "SH" indicating any two (Acute Neurologic Condition, SLP-related Comorbidity, or Cognitive Impairment), and either a Mechanically Altered Diet or a Swallowing Disorder. The third HIPPS character "N" indicates a nursing CMG of "CBC2" which identifies the clinically complex category with a function score of 6-14 and a PHQ9 of 10 or greater.
Let's practice together on the 2nd example. Using the HIPPS Coding Crosswalk Tool, you will need to identify what CMG each of the HIPPS character maps to, along with the documentation that would be necessary to validate payment for that PDPM category… "
(Allow time for the group to work through understanding documentation required to support the payment classification HIPPS code)

Slide 21:
Let's take a minute to review the coding example and what will be required to support the HIPPS code example.
Read slide. Review supporting documentation needs.

Slide 22:
As a final slide related to HIPPS coding, we should also understand what the default rate HIPPS code will look like. In this case we will see "ZZZZZ." In these circumstances our facility would be reimbursed at the lowest possible per diem rate.

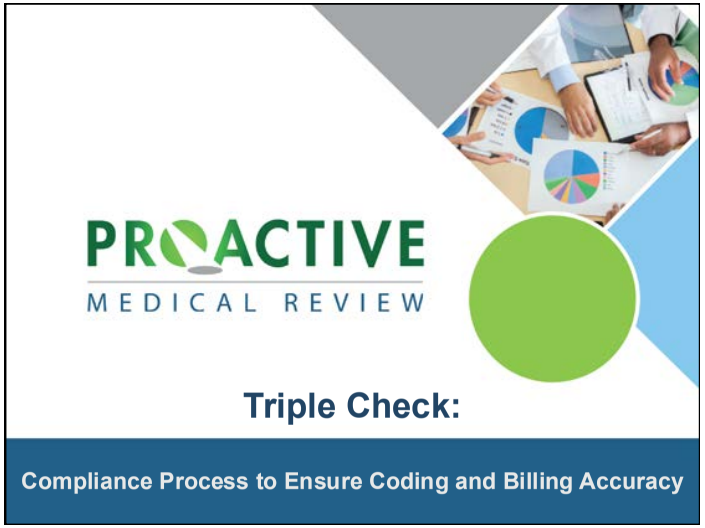
Slide 23:
Language in the Final Rule specifically indicates "the information reported to CMS must be accurate. Inaccuracies in the data reported to CMS, or a failure to document the basis for such data, will necessitate (the same types of) administrative actions." (pg 39198)
Our Triple Check team is a key component of our compliance program. We must be aware of key compliance risks associated with billing accuracy specifically for Medicare Part A benefits. These include but are not limited to:

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

Slide 24:
A few common billing errors that we will specifically need to watch for include:
Submitting claims prior to validating accurate HIPPS code and supporting documentation
Applying inappropriate primary SNF condition that may not be reflective of the qualifying hospital stay
Coding sections of the MDS without an active care need. An example here might be applying the specific ICD10 code required for the dysphagia SLP comorbidity without an active care plan addressing this condition.
Erroneously omission of ICD10 codes to support conditions identified by the NTA, nursing, and SLP categories.
Supporting documentation to accurately capture swallow impairment
Proof of physician oversight such as signed and dated orders, timely physician visits, or compliant SNF certification / recertifications

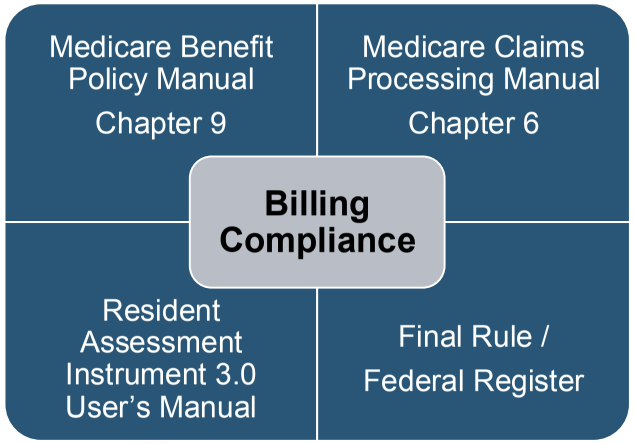
Slide 25:
CMS' core intent with PDPM is "to better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics…" (83 FR 39185). CMS views the PDPM as part of their broader shift from volume to value.

Effective October 1, 201p we must be able to support skilled Medicare patients beyond meeting skilled criteria, and also validate each PDPM component, which includes multiple layers of classification steps to ensure services are tailored to patient needs, or characteristics. This is a new level of complexity and classification. The level of documentation required to support billed services is more crucial than ever. Our facility must have a robust Triple Check process in place to ensure the case mix group assignment and HIPPS codes are coded accurately and well supported through documentation. It is the responsibility of our team to ensure we are compliant in multiple facets.



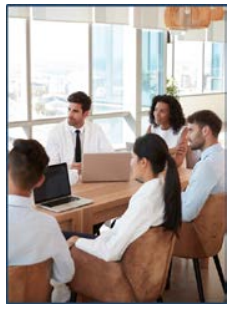
Objectives

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



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

PROACTIVE MEDICAL REVIEW 5

Triple Check Team

Business Office

MDS Department

Rehab Department

Clinical DNS/ADNS

Administrator / Executive Director

PROACTIVE MEDICAL REVIEW 6

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

PROACTIVE MEDICAL REVIEW 7

Administrator / Executive Director

Pre-bill Process

Communication Effectiveness

SNF Certification

Physician Visits

PROACTIVE MEDICAL REVIEW 8

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 the 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*

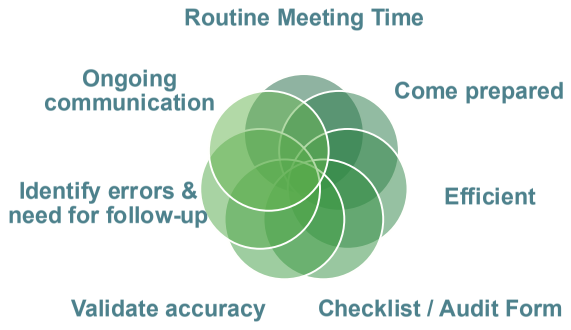
RAI Nurse Representative

- 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



PROACTIVE MEDICAL REVIEW 13

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 *Z0500B date ≤14 days from ARD A2300*			
Timely MDS transmission *Z0500B date ≤ + 14 days*			
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

PROACTIVE MEDICAL REVIEW 16

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

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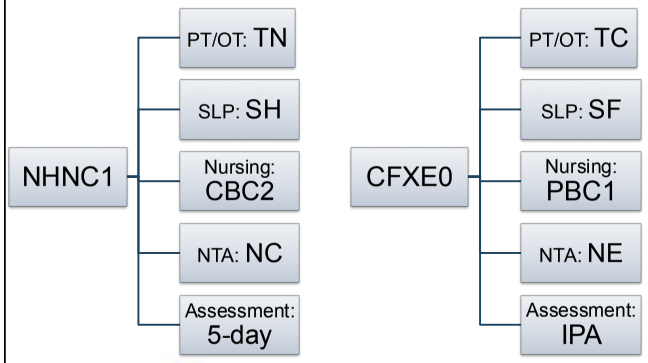
HIPPS Coding Examples



PROACTIVE MEDICAL REVIEW 20

5 Character HIPPS Code Example (CFXE0)		
Character	**Component**	**HIPPS Code Explanation**
1	PT/OT Payment	*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.*
2	SLP Payment	*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.*
3	Nursing Payment	*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.*
4	NTA Payment	*E – (NE) Documentation must support presence of certain comorbidities or use of certain extensive services which total NTA score range 1-2.*
5	AI	*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.*

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)

PROACTIVE MEDICAL REVIEW 22

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

PROACTIVE MEDICAL REVIEW 23

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

PROACTIVE MEDICAL REVIEW 24

Triple Check Compliance Teamwork

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

Triple Check Policy & 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 –

Triple Check Policy Effective Date: _____

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

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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 & REVISIONS			
Version #: Date:			
Summary of Changes:			
Version #: Date:			
Summary of Changes:			

Triple Check Policy Effective Date: _____

Triple Check: Process to Ensure Billing & Coding Accuracy - Post-Test

Name: _____ Title: _____

Date:

1. **The primary purpose of the Triple Check process is to:**
   a. Ensure 3 facility designees agrees with the services billed
   b. Decrease billing errors and promote continual compliance for billing practices
   c. Identify necessary modifications to apply to the Medicare claim
   d. Pre-bill review to check MDS accuracy

2. **Under the Patient Driven Payment Model (PDPM), it will still be necessary to validate accuracy of the SNF certification / recertification for the skilled stay**
   a. True
   b. False

3. **The MDS will be the main document to review for accuracy.**
   a. True
   b. False

4. **The following records are necessary for an effective Triple Check meeting:**
   a. UB04, or Medicare claim for services
   b. SNF Certification / Recertification
   c. Physician, nursing, and therapy documentation
   d. MDS assessments
   e. Both A and D
   f. All of the above

5. **It is acceptable for the business office to submit the claim for payment as long as the team has identified and assigned necessary follow-up for clarifications.**
   a. True
   b. False

6. **The primary purpose of the Triple Check process is to:**
   a. Ensure 3 facility designees agrees with the services billed
   b. Decrease billing errors and promote continual compliance for billing practices
   c. Identify necessary modifications to apply to the Medicare claim
   d. Pre-bill review to check MDS accuracy

7. **Under the Patient Driven Payment Model (PDPM), it will still be necessary to validate accuracy of the SNF certification / recertification for the skilled stay.**
   a. True
   b. False

Test continued on next page...

8. **The MDS will be the main document to review for accuracy.**
   a. True
   b. False

9. **The following records are necessary for an effective Triple Check meeting:**
   a. UB04, or Medicare claim for services
   b. SNF Certification / Recertification
   c. Physician, nursing, and therapy documentation
   d. MDS assessments
   e. Both A and D
   f. All of the above

10. **It is acceptable for the business office to submit the claim for payment as long as the team has identified and assigned necessary follow-up for clarifications.**
   a. True
   b. False

Triple Check: Process to Ensure Billing & Coding Accuracy - Post-Test Answers

Name: _____ Title: _____

Date:

1. **The primary purpose of the Triple Check process is to:**
   a. Ensure 3 facility designees agrees with the services billed
   b. Decrease billing errors and promote continual compliance for billing practices
   c. Identify necessary modifications to apply to the Medicare claim
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   c. Identify necessary modifications to apply to the Medicare claim
   d. Pre-bill review to check MDS accuracy

7. **Under the Patient Driven Payment Model (PDPM), it will still be necessary to validate accuracy of the SNF certification / recertification for the skilled stay.**
   a. True
   b. False

Test continued on next page...

Triple Check: Process to Ensure Billing & Coding Accuracy - Post-Test Answers

8. **The MDS will be the main document to review for accuracy.**
   a. True
   b. False

9. **The following records are necessary for an effective Triple Check meeting:**
   a. UB04, or Medicare claim for services
   b. SNF Certification / Recertification
   c. Physician, nursing, and therapy documentation
   d. MDS assessments
   e. Both A and D
   f. All of the above

10. **It is acceptable for the business office to submit the claim for payment as long as the team has identified and assigned necessary follow-up for clarifications.**
    a. True
    b. False

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PROACTIVE LTC CONSULTING

Facility:			
Date of review:		Payor:	
Review period:		to	

Clean Claim Checklist

	Patient Name/HIPPS Code														
Business Office															
1. Verify resident name, DOB, sex, NBI # against MCR card and CWF															
2. Verify the qualifying hospital stay															
3. Verify co-insurance days															
4. Verify admission/re-admission date															
5. Verify census days/room and board to UB-04 billed days (review LOA)															
6. Verify benefit days available per Common Working File (CWF)															
7. Check for Medicare Secondary Payer (MSP)															
Executive Director / Administrator															
8. MD completed & signed SNF cert within 72 hours of admission; recert on or before day 14															
9. 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															
10. Verify due date for physician initial (within 30 days of admit) and subsequent visits with progress note review.															
RAI Nurse															
11. Primary reason for skilled stay ICD10CM appropriately represented in MDS I0020B															
12. 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															
13. ARDs per each MDS (5-day & optional IPA) accurate to UB-04															
14. HIPPS code(s) accurate to UB-04 and documentation supports each component															
a. PT/OT Payment Group/Surgical Procedure Code															
b. SLP Payment Group															
c. NTA Payment Group															
d. Nursing Payment Group															
15. Number of units on UB-04 corresponds with assessment type															
16. Confirm MDS verified/ signed timely by relevant disciplines															
17. Timely MDS completion *Z0500B date ≤14 days from ARD A2300*															
18. Timely MDS transmission *Z0500B date ≤ + 14 days*															
19. MDS transmission accepted into QIES per validation reports															
20. Care plan supports MDS, skilled service (teaching, condition changes)															

Clean Claim Checklist

DON or Nursing Designee															
21. All physician orders are signed and dated in a timely manner															
22. Verify that physician orders have been obtained and implemented.															
23. Verify daily skilled clinical documentation during the dates of service.															
24. Nursing notes justify skilled need for full duration (skilled nursing, rehab nursing procedures, skilled care planning, teaching, etc.)															
25. Significant change supporting rehab SOC is clear; PLOF documented objectively for therapy goal areas outside of therapy records															
26. Admission assessment is completed within 24 hours of admission															
27. 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)															
28. Is care plan up to date, reflect skilled nursing management, signed															
Therapy															
29. Rehab supported with weekly justification of medically necessity based on clinical needs full duration															
30. Rehabilitation services are stated on physician orders, and signed/dated appropriately															
31. Physician/NPP signed & dated therapy POC/UPOC forms timely															
32. Primary and treatment diagnoses are present															
33. Timely therapy progress reports are present per payer guidelines															
34. Rehab mins/days accurate MDS for each assessment period compared to therapy logs per payer guidelines (ie. Managed Care).															
35. The total amount of group/concurrent minutes, combined, is < 25% of the total amount of therapy for each discipline (MCR A)															
36. Therapy units/mins/HIPPS/ARD match on UB-04, MDS, & rehab doc															
Medicare Meeting															
37. Interdisciplinary communication at least weekly to confirm daily skilled need based on clinical condition(s), documentation, DC															

Signatures/Credentials	Initials	Signatures/Credentials	Initials

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Patient Driven Payment Model (PDPM) HIPPS Coding Crosswalk

PT/OT Component HIPPS Guide			
Clinical Category	**Function Score**	**PT-OT Case-mix Group**	**HIPPS Character**
Major Joint Replacement or Spinal Surgery	0-5	TA	A
	6-9	TB	B
	10-23	TC	C
	24	TD	D
Other Orthopedic	0-5	TE	E
	6-9	TF	F
	10-23	TG	G
	24	TH	H
Medical Management	0-5	TI	I
	6-9	TJ	J
	10-23	TK	K
	24	TL	L
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	M
	6-9	TN	N
	10-23	TO	O
	24	TP	P

SLP Component HIPPS Guide			
Acute Neurologic Condition, SLP-related Comorbidity, or Cognitive Impairment	**Mechanically Altered Diet or Swallowing Disorder**	**SLP Case-mix Group**	**HIPPS Character**
None	Neither	SA	A
None	Either	SB	B
None	Both	SC	C
Any one	Neither	SD	D
Any one	Either	SE	E
Any one	Both	SF	F
Any two	Neither	SG	G
Any two	Either	SH	H
Any two	Both	SI	I
All three	Neither	SJ	J
All three	Either	SK	K
All three	Both	SL	L

NTA Component HIPPS Guide			
Comorbidities / Conditions	**NTA Score Range**	**NTA Case Mix Group**	**HIPPS Character**
See additional reference for Comorbidities Included in NTA Comorbidity Score and Assigned Points	12+	NA	A
	9-11	NB	B
	6-8	NC	C
	3-5	ND	D
	1-2	NE	E
	0	NF	F

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

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PROACTIVE MEDICAL REVIEW

Patient Driven Payment Model (PDPM) HIPPS Coding Crosswalk

Nursing Component HIPPS Guide

Extensive Services	Conditions / Services	Function Score	Nursing Classification	HIPPS Character
• Tracheostomy care • Ventilator / Respirator • Isolation or quarantine		0-14	ES3	A
		0-14	ES2	B
		0-14	ES1	C

Special Care High		PHQ-9 Score	Function Score	Nursing Classification	HIPPS Character
• Comatose **and** completely dependent or activity did not occur • Septicemia • Diabetes with **both** of the following: 1) Insulin injections for all 7 days; 2) Insulin order changes on 2 or more days • Quadriplegia **with** NFS Score <=11	• COPD **and** SOB when lying flat • Fever with **one** of the following: Pneumonia; Vomiting; Weight loss; Feeding tube **with** requirements[1] • Parenteral/IV feedings • Respiratory Therapy for all 7 days	10 or greater	0-5	HDE2	D
		Less than 10	0-5	HDE1	E
		10 or greater	6-14	HBC2	F
		Less than 10	6-14	HBC1	G

Special Care Low		PHQ-9 Score	Function Score	Nursing Classification	HIPPS Character
• Cerebral palsy **with** NFS <=11 • Multiple sclerosis **with** NFS <=11 • Parkinson's disease **with** NFS <=11 • Respiratory failure **and** oxygen therapy *(while a resident)* • Feeding tube **with** requirements[1] • Two or more stage 2 pressure ulcers **with** two or more selected skin treatments[2]	• Any stage 3 or 4 pressure ulcer **with** two or more selected skin treatments[2] • One stage 2 pressure ulcer **and** one venous/arterial ulcer **with** two or more selected skin treatments[2] • Foot infection **or** diabetic foot ulcer **or** other open lesion of foot **with** application of dressings to the feet • Radiation treatment *(while a resident)* • Dialysis treatment *(while a resident)*	10 or greater	0-5	LDE2	H
		Less than 10	0-5	LDE1	I
		10 or greater	6-14	LBC2	J
		Less than 10	6-14	LBC1	K

Clinically Complex	PHQ-9 Score	Function Score	Nursing Classification	HIPPS Character
• Pneumonia	10 or greater	0-5	CDE2	L
• Hemiplegia/hemiparesis with NFS <=11	Less than 10	0-5	CDE1	M
• Open lesions (other than ulcers, rashes, and cuts) **with** any selected skin treatment[3] **or** surgical wounds	10 or greater	6-14	CBC2	N
• Burns	10 or greater	15-16	CA2	O
• Any of the following while a resident: Chemotherapy; Oxygen therapy;	Less than 10	6-14	CBC1	P
• IV medications; Transfusions	Less than 10	15-16	CA1	Q

Behavioral Cognitive Symptoms	Restorative Programs	Function Score	Nursing Classification	HIPPS Character
• BIMS Summary Score <=9 **OR** CPS >=3 • Hallucinations • Delusions	2 or more	11-16	BAB2	R
• Any of the following 4 or more days: Physical behavioral symptoms directed toward others; Verbal behavioral symptoms directed toward others; Other behavioral symptoms not directed toward others; Rejection of care; Wandering	0 or 1	11-16	BAB1	S

Reduced Physical Function	Restorative Programs	Function Score	Nursing Classification	HIPPS Character
• Behavioral Symptoms and Cognitive Performance with NFS <11 • Residents who do not meet the conditions in any of the previous categories • Restorative Nursing Services administered for 6 or more days	2 or more	0-5	PDE2	T
	0 or 1	0-5	PDE1	U
	2 or more	6-14	PBC2	V
	2 or more	15-16	PA2	W
	0 or 1	6-14	PBC1	X
	0 or 1	15-16	PA1	Y

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Patient Driven Payment Model (PDPM) HIPPS Coding Crosswalk

HIPPS Code Worksheet

Resident:	NBI #:
Admit Date:	Last Covered Day:
Primary Payor:	Secondary Payor:
5 Character HIPPS Code:	

Character Place	PDPM Component	HIPPS Character	Case Mix Group	Reason(s) for Case Mix Group Qualification
Example: Character 1	PT / OT Payment	N	TN	Non-ortho surgery; GG score = 7
Character 1	PT / OT Payment			
Character 2	SLP Payment			
Character 3	NTA Payment			
Character 4	Nursing Payment			
Character 5	Assessment Indicator		☐ 5-Day ☐ IPA	

Comments:

Interdisciplinary Team Members:	