Reimbursement

Refresh Your 'Triple Check' To Get The Reimbursement You Deserve

Find out which key staff members you should include in the process.

Auditing your own MDS records for accuracy before submitting them is crucial to not only ensuring appropriate reimbursement, but also meeting quality measures, evaluating care planning and mitigating any survey impacts. And if you aren't using a Triple Check process before you submit your MDS records and billing to Medicare, you could be in a world of hurt.

Background: The Triple Check is a three-point check system to review each Medicare beneficiary's UB-04 claim before you submit the bill to Medicare, according to a July 11 presentation at the **Florida Health Care Association** (FHCA) 2014 Annual Conference & Trade Show by **Pamela Petsopoulos, PT, RAC-CT** and **Kathy Russell, RN, BSN, RAC-CT** of **Solaris Rehab, LLC**. The process includes reviewing the:

1. MDS RUG code and applicable billing days;
2. MDS submission date and acceptance; and
3. Assessment Reference Date (ARD) date and Health Insurance Prospective Payment System (HIPPS) code for accuracy and compliance.

You can perform the Triple Check during the Encoding Period, which "is the seven days after the completion of the MDS during which the facility staff should ready the assessment for submission," explained **Kris Mastrangelo**, president and CEO of Topsfield, MA-based **Harmony Healthcare International** in a company blog posting.

"Unfortunately, many nursing home clinicians are unaware of this period or unaware of the intent of it," Mastrangelo noted. "Diligent use of the Encoding Period and a solid Triple Check system are but two examples of processes needed to manage the complexities of prospective payment for maximizing and insulating revenue."

Who Should Be Involved in the Triple Check

Ideally, the Triple Check process should take place at least monthly and should involve the entire Medicare team's participation, Petsopoulos and Russell asserted. MDS, therapy, business office, medical records, social services and other relevant staff members should be involved.

At a minimum, Triple Check meeting attendees should include the administrator, director of nursing or designee, MDS nurse and representatives for each discipline, advised health care consulting firm **Boyer & Associates, LLC** in a recent educational session for the **Pennsylvania Health Care Association**.

What Items You Need to Review

Strategy: Look closely at all the specific directions (buttons, keys, check points, etc.) from your MDS software vendor regarding the opportunities to screen data prior to closing/locking, as well as before completing sections of the MDS and total submission of the MDS, Boyer & Associates recommended. "You must know your software and utilize these steps prior to closing each section and/or the total MDS."

In the Triple Check, you'll review the claims for data and coding accuracy, as well as field level placement on the UB-04 form, Petsopoulos and Russell instructed. Make sure you check off the following crucial review items:

- ✓ Dates of Service
- ✓ Diagnosis for Skilled Service
- ✓ ICD-9 Numbers Correspond to Diagnosis
- ✓ Hospital Stay Dates
- ✓ Physicians Certification/Recertification Signed and Dated Properly
- ✓ Physicians Orders for Skilled Services (IV, PT, OT, ST, etc.) Signed/Dated
- ✓ Therapy POC Signed/Dated
- ✓ MDS ARDs
- ✓ MDS Item O0400 — *Therapies* Days/Minutes Match the Service Log Matrix
- ✓ NOMNC Delivered Timely and Accurately
- ✓ MDS Acceptance Date in UNIX
- ✓ Nursing Documentation Support Medical Necessity
- ✓ MDS Section G — *Functional Status* is Supported in the Clinical Record
- ✓ Therapy Documentation Includes all Required Areas
- ✓ Release Claim

Comb Through Important Data Points in Your MDS Records

And according to Boyer & Associates, you can utilize your MDS software's various functions to complete a comprehensive pre-screening. Follow these steps to perform an MDS-focused pre-submission process:

- Search for and examine the MDS records planned for submission while they're in a "Draft form of the Batch;"
- Use the Draft form of the Batch list as a "Proposed Batch list" until you've thoroughly examined the details with each MDS for submission;
- Identify and/or verify any unplanned or avoidable "errors" for each MDS in the Proposed Batch list by running a total MDS validation/error/logic check (software packages use different terms);
- Examine each MDS, including the prior MDS records in the Draft form of the Batch, to assure order/sequencing of the MDS records for each resident;
- Examine some specific MDS sections, such as Section O — *Special Treatments, Procedures, and Programs*, for accuracy prior to submitting the Proposed Batch list;
- Examine Section A coding of event date information for each MDS regarding:
    - A0200 — *Type of Provider*,
    - A0310 — *Type of Assessment*,
    - A1600 — *Entry Date* on an entry tracking record,
    - A2000 — *Discharge Date* on a discharge/death in facility record,
    - A2300 — *Assessment Reference Date* on an OBRA or PPS assessment, and
    - A2400 — *Medicare Stay* (Medicare start of care date).
- Verify that the RN Assessment Coordinator signed and dated Section V — *Care Area Assessment (CAA) Summary* if this is a comprehensive assessment;
- Verify that item Z0400 — *Signatures of Persons Completing the Assessment or Entry/Death Reporting* includes dates when interviews were completed, and that item Z0500 — *Signature of RN Assessment Coordinator Verifying Assessment Completion* is signed and dated;

- Confirm any ongoing or facility-known areas of risk or concern, such as new staff completing MDS records, system issues with software, or performance-related/quality assurance problems;
- Examine the validation of the RUG levels identified in Section Z for each MDS to ensure appropriateness with the clinical picture of the resident, funding source, type of MDS record, and overall accuracy of the information;
- Look for any conflicts, errors or logic issues that the multi-disciplinary team has identified with the specific section reviews prior to the scheduled completion of each MDS section (if possible with your software); and then
- Go back to the MDS sections of the MDS records in the Proposed Batch list to identify whether this validation was not completed through error/logic checks, if flagged or a risk area (per specific software validation guidelines).

Make sure that the discipline writing the documentation is not the same one reviewing it during the Triple Check process — this allows "fresh eyes" to see whether the information is truly supportive of the MDS coding, advises **Marilyn Mines, RN, BC, RAC-CT**, *MDS Alert* consulting editor and senior manager of clinical services for **FR&R Healthcare Consulting Inc.** in Deerfield, IL. Also review the HETs to ensure that nothing has changed from the time of admission that might impact coverage or reimbursement.

Bottom line: Using a Triple Check process may seem like a big undertaking, but experts agree that you can't afford not to. Because federal oversight of your Medicare Part A-related practices are greater than ever, according to Mastrangelo, the Triple Check is a crucial weapon in your facility's fight to ensure proper reimbursement and avoid sticky compliance problems.

Sample Doc

Use This Handy Checklist To Streamline Your Triple-Check Process

Keep your team on-track by utilizing a comprehensive form.

If you want to simplify and perfect your Triple Check at the same time, try using a checklist form. Here's a sample form, courtesy of **Affinity Health Services**, a firm that provides senior community management and consulting services, headquartered in Indiana, PA (www.affinityhealthservices.net):

Part A – Pre-Transmittal UB-04 Triple Check Form

Resident Name: _____ Facility: _____
Dates of Service: From _____Through _____ Billing Month/Year: _____

Business Office, Nursing and Rehab to assess: place a (√) check in the first column when the standard is met. (X) for NOT MET

MET	COMPLIANCE STANDARD	SOURCE
	1. Beneficiary's name correct per CWF Screen	Common Working File
	2. Birthday correct per CWF screen	Common Working File
	3. Sex correct per CWF	Common Working File
	4. Status Correct	
	5. MSP form completed on admission and readmission	Financial records
	6. Beneficiary's Medicare number is correct per CWF	Common Working File
	7. NPI / UPIN number and doctor's name is correct	**UB04**
	8. Remarks for processing claim are present	**UB04**

Business Office, Nursing and Rehab to assess: place a (√) check in the first column when the standard is met. (X) for NOT MET

MET	COMPLIANCE STANDARD	SOURCE
	9. Bill type is correct	UB-04
	10. Dates of Service are correct	Medicare/PPS Scheduler Report
	11. Most current admission date matches UB-04 and record	UB-04 and medical record
	12. Hospital stay dates matches between UB-04 and record	UB-04 & medical record
	13. HIPPS (MDS Section Z) codes match UB-04	UB-04 and MDS
	14. For Rehab RUG, PT, OT, ST charges are correct	UB-04 and rehab logs
	15. Significant changes and or OMRAs are billed correctly	MDS and UB-04
	16. MDS ARD matches UB-04 service dates	MDS and UB-04
	17. ARD falls within required timeframe	MDS
	18. Number of days billed for each MDS are correct	Medicare/PPS Scheduler and UB-04
	19. Pharmacy charges are only for legend meds used during the dates of services billed	Pharmacy Invoice
	20. Med surg charges are only for coverable items used during the dates of services billed	Supply invoices
	21. Nursing documentation supporting Medical necessity	MDS, medical record
	22. MDS Sections G and O is supported in the record	MDS and medical record
	23. Diagnoses for skilled services accurate and matches between the MDS, UB-04 and therapy logs	MDS, UB-04, therapy logs
	24. Diagnoses are appropriately coded	MDS and UB-04
	25. Rehab medical and treatment DX are present and Correct	UB04
	26. A signed order is present to "admit to skilled care"	Physician Orders
	27. Physician certification / recert is timely, accurate and complete	Progress notes / Cert-Recert form
	28. Rehab Orders / Plan of Care / Updated plan of care are signed and dated by the physician	Medical record
	29. Denial notices completed timely and accurately	Financial folder

I certify that the accompanying information accurately reflects resident assessment and tracking information for this resident and that I collected and/or coordinated collection of this information in accordance with applicable Medicare/Medicaid requirements. I understand that this information is used as a basis for insuring that residents receive appropriate and quality care and as a basis for federal funds and such conditions is based on the accuracy and truthfulness of this information, that I maybe personally subject to or subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.

_____	Administrator	_____Date
_____	DON	_____Date
_____	BOM	_____Date
_____	MDS Coordinator	_____Date
_____	Rehab	_____Date