



CONFIDENTIAL

Medicare Billing and RAC Readiness Audit

**Blaire House of Milford
20 Claflin Street
Milford, MA 01757**

Date of Visit: December 7, 2011

Polaris Consultant: Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA

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Site visits by a Polaris Group Consultant

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OVERVIEW

On December 7, 2011, Victor Kintz, Polaris Consultant, provided consulting services for **Blaire House of Milford**. The purpose of this visit was to provide the Medicare Billing and Post Payment Readiness audit.

The objectives were to:

1. Determine procedural accuracy of the Medicare UB-04 claim forms that include therapy services
2. Evaluate the appropriateness of Medicare billing based on Federal guidelines by performing an audit of UB-04s and medical records to evaluate the following:
 - a. Current Medicare billing procedures
 - b. Ensure timely and accurate billing and revenue
 - c. Compliance with Medicare requirements
 - d. Identification of risk areas

All UB-04 and chart audit findings were shared in detail with appropriate staff with recommendations for individual follow-up. Review of findings and recommendations provided during exit meeting.

Please feel free to call me if you have any questions or concerns at [REDACTED].

Interviewed: MDS Coordinator, Rehab Director

Individuals Present at Exit Conference: Administrator

Reviewed: Five (5) Part A Clinical records, Ten (10) MDS Periods, Five (5) Part A UB-04s, Two (2) Part B Clinical Charts, Two (2) Part B UB-04s

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PRIORITIES FOR ACTION PLANNING

Medicare Part A:

Therapy Treatment Duration: The Therapy department appears to be doing a good job of recording treatments to actual minutes performed during the ARD look-back period.

- One patient appeared to have OT minutes ramped up the last day of the look-back period. Treatment time was 15 minutes higher than any other OT treatment performed (total of 107 minutes).
 - The Ultra High RUG was achieved with 5 minutes over.
 - Treatment immediately following this day dropped to only 20 minutes.
- Another patient had a treatment of 95 minutes the last day of the look-back period; 22 minutes higher than any other treatment.
 - Ultra High RUG was achieved with 8 minutes over.

Recommendation: Delivering longer treatment minutes at the end of a look-back period should be avoided if subsequent treatment duration is not supported at the higher level.

Therapy Prior Level of Function (PLOF): The PLOF needs to be objective and concise. Claims are being denied in post payment reviews because the Evaluation does not include an objective and a measureable functional level prior to the decline.

Recommendation: The requirements for PLOF should be reviewed with the Speech Therapist responsible for completing evaluations and follow-up audits should occur to ensure adequate documentation. The Therapy Program Director agreed that this will be followed up on with the clinicians.

Nursing Documentation: The narrative notes from nursing could do a better job explaining the support provided for ADLs. This documentation will support what therapy is doing to meet the medical necessity for the Medicare skilled service. The notes do a good job outlining the skilled nursing needs. For therapy, additional clarification is warranted.

- e.g., “Gets OOB to BR. Assisted to BR” – What assistance was actually provided?
- For some of the charts audited, this documentation is very good.

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PRIORITIES FOR ACTION PLANNING continued

Medicare Part A UB-04s:

Qualifying Stay Dates: One claim did not include most recent qualifying hospital stay dates.

- Occurrence Span Code 70 was used with dates of 07/16/11-08/02/11.
- These dates should have been listed with Span Code 71 (Previous Hospital Stay Dates), and Code 70 should have reflected the most recent stay dates of 10/04/11-10/07/11.

Medicare Part B UB-04s:

Value Codes 50, 51, and 52: Stated Value Codes for noting cumulative number of Treatments for PT, OT and ST respectively is no longer required to be on the UB-04 Claim form effective October 1, 2010.

ADDITIONAL INFORMATION RELATED TO AUDIT

1. The charts reviewed all contained appropriate clinician signatures and dates on supporting documentation except for physician signature on the therapy evaluations.
2. The Physician Certification in use is adequate and allows for the completion of all the required information.
3. V57.xx diagnosis code is being used appropriately.

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BEST PRACTICES

Yes (Y) = MET, No (N) = Not Met N/A = Did not Evaluate. All findings are based on charts audited or other data gathered during visit.

Eligibility		Comments
Y	Three day hospital stay met on charts audited	
Y	Upon admission, method in place to obtain number of Medicare days available	
Y	Proper notification of non coverage at time of admission, continued stay, or exhaustion of benefits (denial letters or ABNs) for Part A	
Y	Proper notification of non coverage for Part B services e.g. therapy.	
Y	Proper notification of expedited review (Generic and Detailed Notices) for Part A	
Y	Proper notification of expedited review (Generic and Detailed Notices) for Part B	
N	Effective procedures in place to respond to a Additional Development Request (ADR) or Recovery Audit Contractor (RAC) requests	Company has a policy for responding to ADRs. As ADR is generic for any post payment audit, this should suffice.
Y	Proper submission of No Pay claims.	

Physician Certifications Part A - Based on charts audited		Comments
Y	Physician Certification for Skilled Level of Care reviewed had complete information per regulations meeting requirements (physician documentation, hospital form with required information signed and dated, or certification form)	
Y	Physician Certifications for Skilled Level of Care reviewed were dated and signed by physician	
	- Missing Signature (physician name stamps are not allowed)	
Y	- No date by physician with signature and no indication of date received (fax date, stamp date)	
Y	Physician Certifications for Skilled Level of Care reviewed were completed, dated and signed on or before due date	

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Physician Compliance and Plan of Treatments- Based On Part A Charts Audited		Comments
Y	Physician orders for skilled services	
N	Initial Order/telephone order for Evaluation and Treat is signed and dated by physician	Multiple patients had the Eval and Treat orders combined with the Clarification Orders. These should be 2 separate physician orders. Combining the orders in to one may give the appearance that the Evaluation was completed prior to obtaining the order. Otherwise, how would they know the Plan of Treatment?
Y	Clarification order/telephone order returned and signed and dated by physician	
Y	Clarification order includes modality, frequency, duration, and type of the therapy.	
Y	Plan of Treatment complete. If not, indicate missing info below	
Y	— Documentation by physician (e.g. current and signed skilled LOC certification, or signature and date on evaluation form, or noted in progress note, or detailed clarification order which should include diagnosis and goals).	
Y	— Modality	
Y	— Clarification orders include Group minutes modality	
Y	— Frequency	
Y	— Duration	
Y	— Prior Level of Function	
Y	— Measurable time limited goals	
Y	— Medical diagnosis and treatment diagnosis	
Y	— Onset date	

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Physician Certifications Part A - Based on charts audited		Comments
Y	— Start of Care date	
Y	— End of month summary	
Y	Daily encounter note matches therapy service logs	
Y	Weekly Summary notes by modality	
Y	Source document (e.g. therapy services log) for treatment minutes accurate in medical record,	
Y	Actual minutes are usually coded without a pattern of rounding	Although, it was noted on 2 patients that longer treatments for OT services were offered on the last day of the look- back period while subsequent treatments did not maintain that treatment duration.
Y	Physician approval of significant changes in treatment plan.	

Recommendations

- Therapy treatment times should not show a marked increase on the last day of the look-back period if subsequent treatments do not also reflect this increase in time spent during therapy.
- Eval and Treat orders should be a separate order from the Clarification Order.

Part B Therapy Documentation Requirements

Y	Physicians orders for evaluation and treatment as indicated	
Y	Once order is obtained, timely referral to therapy with a timely evaluation.	
Y	Clarification order includes modality, frequency, duration, and type of therapy.	
Y	Plan of Treatment complete. If not, indicate missing info below	
Y	— Modality	

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Part B Therapy Documentation Requirements		
Y	— Frequency	
Y	— Duration (this impacts when the next recertification if any will be indicated)	
Y	— Prior Level of Function	
Y	— Measurable time limited goals	
Y	— Medical diagnosis and treatment diagnosis	
Y	— Onset date	
Y	— Start of care date	
Y	Physician Certification: Physician approval with date and signature of the initial POT constitutes certification of the POT (NP, Clinical Nurse Specialist, or PA).	
Y	Physician Recertification: Recertification of POT is required based on an appropriate length of time based on resident needs/treatment plan, limited to no longer than 90 days.	
Y	Documentation of each Treatment daily encounter note includes the following required elements:	
Y	— Date of treatment;	
Y	— Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding.	
Y	— Total timed code treatment minutes and total treatment time in minutes.	
Y	— Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment.	

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Part B Therapy Documentation Requirements		
Y	Documented review of Plan of Treatment. If not, indicate missing information below	
Y	— Updated POC at timely intervals (timing can be impacted by state practice act; e.g. at least every 30 days)	
Y	— Physician signature is only required if a recertification is indicated.	
Y	— Modality	
Y	— Frequency	
Y	— Duration	
Y	— Measurable and time limited goal	
Y	— Medical Diagnosis and Treatment Diagnosis	
Y	— Onset Date	
Y	Progress Note noted at least after every 10 treatments --- 10 treatment days – if BID treatments are done, could have 20 treatments prior to required Progress Note.	

UB-04 Audit - Based On UB-04s Audited for Part A and B		Comments
Y	UB-04 coding accurate (Bill type, days etc).	
Y	— Bill type appropriate for resident current status	
Y	— Days billed for 5, 14, 30 MDS meets PPS days requirements	
Y	— Billed day count accurate not including day of discharge	
Y	— Are charges listed appropriately on UB-04? (Proper charge coding, actual charges when per-diem contracts are in place)	
Y	— Diagnosis coding on UB-04 is justified in corresponding medical record.	

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UB-04 Audit - Based On UB-04s Audited for Part A and B		Comments
Y	— Primary and/or secondary diagnosis support therapy as a skilled services	
Y	— Evidence of facility following Consolidated Billing Regulations	
Y	Does coding on MDS ARD and MDS reasons match the UB-04 Service dates and modifiers	
Y	Facility capturing ancillary charges and in-house medical supply charges	
Y	Systems to track for Part B caps and process to bill automatic and manual exceptions.	
Y	Procedures in place to submit no pay and exhaust claims as required.	Corporate billing office responsible.

Communication System Nursing To Billing		Comments
Y	Evidence of communication of key information between MDS Coordinator and Facility Billing Representative	
Y	Billing Representative attends facility Medicare meeting	
Y	Therapy minutes coded on MDS are validated in the record and communicated to billing	
Y	ICD-9 coding accurate and communicate to billing office.	
Y	Diagnosis codes are removed from UB-04 when resolved during Medicare A stay.	
Y	Understanding of consolidated billing rules evident	
Y	Management of diagnostic services that fall under consolidated billing noted i.e. Diagnostics performed prior to day of discharge from hospital, use of preferred providers, notification to hospital of Part A status when receiving services.	

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The following modules are available within the current RehabPlus product contract. Your Polaris Consultant, Amy Snetsky, will be contacting you to review modules already provided and the remaining visits available to determine future services.

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| <ul style="list-style-type: none"> • RUG-IV Training • Return to Hospital Review • Billing Training to MDS 3.0 and RUG-IV • Medicare and MDS 3.0 Accuracy Reviews • Medicare Case Management Review • MDS 3.0 Coding and Interview Training • 5 Star Analysis • NY CMI Review • TX CMI Review • PA CMI Review | <ul style="list-style-type: none"> • Medicare Billing Audit and RAC Readiness Review • Census Development • Ancillary Cost Management • Quality Management and Citation Prevention Training • CAAs and Care Plan Review • Clinical Survey Snapshot • Medicare Business Office Snapshot • Nursing Documentation to Support Medical Necessity • Part B Utilization and Nursing Restorative Program • ADL Review and Training |
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In addition to the services currently provided within the RehabPlus contract, the following Polaris Group services are available by separate Letter of Agreement:

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| <ul style="list-style-type: none"> • RUG-IV training for Medicare Team • RUG-IV training for Billing staff • MDS Analyzer and Risk Management Reports – Apollo RM • Comprehensive Medicare Revenue Management Review • Medicare Billing Services • Risk Management • Billing training including “A Guide to Medicare Billing” Manual • New DON and MDS Nurse orientation | <ul style="list-style-type: none"> • Key Indicator Trends (KIT reports) • Supervisory Skill Training and Team Building, designed to decrease turnover Live Teleconference Trainings • Medicare ADR/Denials and Pre/Post Payment Review Support • OBRA Mock Pre-survey (to assist with preparation for annual state survey process) • Cost Reports • Corporate Compliance |
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