

CONFIDENTIAL

Medicare Billing and RAC Readiness Audit

**Brandon Woods of Dartmouth
567 Dartmouth Street
South Dartmouth, MA 02748**

Date of Visit: October 4, 2012

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

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Site visits by a Polaris Group Consultant

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

OVERVIEW

On October 3, 2011, Victor Kintz, Polaris Consultant, provided consulting services for **Brandon Woods of Dartmouth**. 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, and
 - 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. With the full time MDSC out for recent emergency surgery items were not

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

**Individuals Present
at Exit Conference:**

MDS Coordinator, Rehab Director

Reviewed:

Four Medicare Part A clinical records, 11 MDS Periods, four Medicare Part A UB-04s, one Medicare Part B clinical charts, one Medicare Part B UB-04.

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

PRIORITIES FOR ACTION PLANNING

Medicare Part A:

Physician Certification/Re-Certifications: Physician Certifications and Re-Certifications are needed from the physician to verify the need for the skilled service.

- Some of the Physician Certification/Re-Certifications were missing at the time of this audit.
- Two patients had the Physician Certifications and Re-Certifications included in the record and were signed by the physician timely.

Recommendation: Physician Certifications and Re-Certifications should be obtained timely and stored in the clinical record. The current process for obtaining and filing these should be reviewed.

Diagnosis Coding: Therapy Treatment Diagnosis Codes are consistently not getting on the UB-04 claim form, or are not accurate for that claim period.

- PT and OT treatment diagnosis codes are not getting into the system, and thus not getting on the claim.
- One Medicare Part B claim for Occupational Therapy used Diagnosis Code v57.89 for Multiple Therapies. The correct code is V57.21.

Recommendation: Therapy Treatment Diagnosis Codes should be included on all Medicare claims. They should also be added to the appropriate MDS.

Therapy Treatment Duration: A pattern was discovered of rounding treatments to either the nearest 5 minute increment, or the same number of treatment minutes for multiple treatments. Seventy-two was a favorite number for treatment duration.

- Each patient reviewed had some pattern of rounding the treatment duration.
- Eight of 11 MDSs were within 10 minutes of the minimum number of minutes needed to achieve the Rehab RUG.

Recommendation: Actual minutes of treatment should be recorded.

**Medicare Billing and RAC Readiness Audit
Brandon Woods of Dartmouth**

PRIORITIES FOR ACTION PLANNING, continued

Therapy Evaluations: It is the policy of the facility to have Therapy Evaluations signed by the attending physician.

- Four of four Medicare Part A records did not have the signed evaluation by the Physician at the time of this audit. Some went back to August.
- One Medicare Part B evaluation was signed, but the signature was not dated.

Recommendation: The process of obtaining Physician signatures for therapy evaluations should be reviewed to ensure this process occurs timely. Audits should also be performed to ensure this is accomplished. The signatures should also be dated by the physician, or date stamped when received signed by the facility.

Therapy Evaluation Orders: Therapy orders should be obtained prior to the initiation of treatment.

- Initial “Eval and Treat” orders were missing for one Speech patient, and another missing for an Occupational Therapy patient.

Recommendation: Physician orders should be validated by the clinician prior to the initiation of services.

Therapy Treatment Logs: Accurate therapy treatment logs should be filed in the clinical record.

- One clinical record had an inaccurate weekly therapy services log in the clinical record and, as a result, the therapy minutes coded on the MDS did not match the therapy logs.
 - An updated services log was produced showing accurate minutes. Apparently, the computer system was down for a period requiring hard copy tracking of minutes and the system was not updated prior to the printing of the inaccurate form that was filed in the chart.
 - The Rehab Director will ensure accurate documents are filed in the clinical record.

Recommendation: A quick audit should be done on all patients who were treated while the electronic system was down to ensure accurate minute logs are filed in the chart.

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

PRIORITIES FOR ACTION PLANNING, continued

Therapy “Prior Level of Function”: An objective PLOF should be documented by the treating discipline on the evaluation form.

- Speech Therapy’s PLOF is not always objective and could place the Speech Therapy services at risk for denial in an audit.

Recommendation: Training on how to write objective PLOF should be delivered to the SLP.

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	

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Physician Certifications Part A - Based on charts audited		Comments
	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)	
N	Physician Certifications for Skilled Level of Care reviewed were completed, dated and signed on or before due date	Two patients were missing signed Physician Cert/Re-certification forms.
Recommendations		
<ul style="list-style-type: none"> Charts should be audited periodically to ensure that all certs include all required information including relation to acute care stay. A delayed Physician Cert should be obtained for the Medicare Part A services referenced to cover this technical requirement for coverage. 		

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	Both OT and ST were missing the initial Eval and Treat orders for at least one patient in this audit sample.
Y	Clarification order/telephone order returned and signed and dated by physician	
Y	Clarification order includes modality, frequency, duration, and type of the therapy.	
N	Plan of Treatment complete. If not, indicate missing info below	Physician Signatures were noted missing from some of the Therapy Evaluations.
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	

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

Physician Compliance and Plan of Treatments- Based On Part A Charts Audited		Comments
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	
Y	— Start of Care date	
Y	— End of month summary	
N	Daily encounter note matches therapy service logs	One patient had a weekly services log in the clinical record, which had not recorded all treatments delivered due to the software being down for a short period.
Y	Weekly Summary notes by modality	
N	Source document (e.g. therapy services log) for treatment minutes accurate in medical record,	One patient had a weekly services log in the clinical record, which had not recorded all treatments delivered due to the software being down for a short period.
N	Actual minutes are usually coded without a pattern of rounding	Patterns were noted with '72' being the most popular number of minutes recorded for treatment duration.
Y	Physician approval of significant changes in treatment plan.	
Recommendations		

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

Physician Compliance and Plan of Treatments- Based On Part A Charts Audited	Comments
<ul style="list-style-type: none"> • Accurate therapy service logs should be filed into the record after month end. • Therapy Evaluations should be signed by the physician timely. 	

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	
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	
N	Physician Certification: Physician approval with date and signature of the initial POT constitutes certification of the POT (NP, Clinical Nurse Specialist, or PA).	Medicare Part B records reviewed lacked physician certification due to the certification dates not being included on the evaluation form.
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.	

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

Part B Therapy Documentation Requirements		
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.	
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	

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

Part B Therapy Documentation Requirements	
	treatments are done, could have 20 treatments prior to required Progress Note.

Recommendations:

- Recommend Delayed Physician Certification for Medicare Part B record that currently does not have one.
- An audit should be performed of Medicare Part B Therapy Evaluations to ensure Certification Dates are included and that they are in fact signed by the attending physician.

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)	
N	— Diagnosis coding on UB-04 is justified in corresponding medical record.	V57.89 – Multiple Therapies was used for an OT claim. V57.21 is the accurate code for this service.
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.

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

UB-04 Audit - Based On UB-04s Audited for Part A and B		Comments
N	Medicare QA prior to billing; e.g. Triple Check	

Recommendations

- UB-04s should be reviewed for accuracy prior to billing. Although the billing is done at the central billing office, the claim should reflect accurate information and should be reviewed prior to billing. Clean UB-04s should be printed after corrections have been made.

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	
N	ICD-9 coding accurate and communicate to billing office.	See comments related to diagnosis coding listed above.
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.	

Recommendations

- V57.89 should only be used in first position for Medicare claims with “multiple therapies” being billed. Each therapy discipline has an appropriate code if they are the single source providing therapy services to the beneficiary.

Medicare Billing and RAC Readiness Audit Brandon Woods of Dartmouth

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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