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CONFIDENTIAL

Medicare Billing Audit and RAC Readiness Review

Blair House of Milford
20 Claflin Street
Milford, MA 01757

Date of Visit: November 7, 2013

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Polaris Group partnership includes:

- ***Polaris Pulse Newsletter*** faxed to you every other week; includes pertinent updates that impact LTC
- Access to the ***Polaris Group Solution Center 1-800-759-5533*** Available five days a week to answer your questions
- Site visits by a ***Polaris Group Consultant -*** see available consulting at end of this report.

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OVERVIEW

On November 7, 2013, Lisa Archuleta, 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 objective is to determine procedural accuracy of the Medicare UB-04 claim forms that include therapy services, evaluate the appropriateness of Medicare billing based on Federal guidelines by performing an audit of UB-04s and medical records to evaluate the following:

1. Current Medicare billing procedures
2. Ensure timely and accurate billing and revenue
3. Compliance with Medicare requirements
4. 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 at [redacted] if you have any questions or concerns regarding this report.

Number of Charts Audited: **Five Medicare A Charts, One Medicare Part B**

Staff Interviewed: **DON, Therapy, Business Office, MDS, Medical Records**

Individuals Present at Exit Conference: **DON, Therapy, Business Office, MDS, Medical Records**

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PRIORITIES FOR ACTION PLANNING

1. **Diagnosis Coding:** The admitting diagnosis code should be the reason the resident was admitted to the facility. An aftercare code would be appropriate.
   - V57.89 was the admitting diagnosis code on the claims audited.
   - The diagnosis codes on the claims should support the level of care billed and sequenced appropriately.
   - On Medicare Part B, the service logs from therapy must have a validated medical and treatment diagnosis that should correspond to the claim.

   Recommendations: Contact Net Solutions in regard to proper setup of diagnosis codes in the software to ensure the correct admitting diagnosis code and proper sequenced codes are on the UB-04. Ensure all diagnosis codes on the claim are verified in the Triple Check Meeting prior to submission to Medicare.

2. **Therapy Treatment Duration:** A pattern of rounding treatments to either the nearest 5 minute increment, or the same number of treatment minutes for multiple treatments was discovered.
   - Each patient reviewed had some pattern of rounding the treatment duration.

   Recommendation: Actual minutes of treatment should be recorded.

3. **UB-04 Claims:** Correct revenue codes for treatment of Physical, Occupational, and Speech Therapy for a SNF are 420, 430, and 440. The number of Service Units on the claim is the number of days the resident was treated**.**
   - The Service Units on all claims audited were using total treatment units,
   - Revenue Codes for PT, OT, and SLP on the claims had the incorrect codes of 421, 431, and 441.

   Recommendation: The revenue codes and service units on the UB-04 should be corrected in the software to the proper codes and units on Medicare Part A UB-04 claims.

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BEST PRACTICES

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

Admission/Eligibility/Notices		Comments
Y	Three day hospital stay met on charts audited.	
Y	Upon admission, method in place to obtain number of Medicare days available.	
Y	Review of Physician Orders to ensure diagnostics are performed prior to day of discharge from hospital or change in orders as safe and appropriate to meet resident needs.	
Y	Pre-Admission cost evaluation and intervention: Physician Orders immediately reviewed upon admission to ensure cost management within protocols and best practice.	
Y	• Information regarding costs is readily available for admission decision.	
Y	• Pharmacy costs	
Y	• Special equipment/supplies	
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.	
Y	Effective procedures in place to respond to an Additional Development Request (ADR) include organizational oversight of process.	
Y	FISS is checked a minimum of three times a week for ADR status.	

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Admission/Eligibility/Notices		Comments
Y	Proper completion of Medicare as Secondary Payer form for Part A.	
Y	System in place to notify physicians/ER//Vendors when resident is on Part A and falls under consolidated billing rules.	
Y	Therapy notified of admission in advance and orders obtained at time of admission.	
Recommendations		
• None.		

Physician Certification 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 by SNF Attending, or certification form).	
Y	Physician Certifications for Skilled Level of Care reviewed were dated and signed by physician.	
Y	• No Missing Signatures (physician name stamps are not allowed).	
Y	• If therapy is the skilled service, therapy interventions are noted on certification form.	
Y	• Dated by physician with signature or 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.	
Y	Procedures in place for Delayed Certifications which include Delayed Certifications obtained as indicated to ensure compliance prior to billing.	

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Physician Certification Part A - Based on charts audited		Comments
Y	If physician skilled LOC certification is not complete or timely, consider a signature and date on evaluation form (700/701), or in progress note, or detailed clarification order to determine compliance.	
Y	Is Physician signature legible? If not, is a Physician signature log available for review?	
Recommendations		
• None.		

Therapy - Based On Part A Charts Audited		Comments
Y	Physician orders for skilled services.	
Y	Physician orders to evaluate and Treat	
Y	Clarification order/telephone order returned and signed and dated by physician per policy.	
Y	Clarification order includes specific modality, procedures, frequency, duration, and type of the therapy using CPT code terminology per policy.	
Y	Plan of Treatment complete. If not, indicate missing info below:	
Y	• Documentation by physician of approval of POT demonstrated by a complete and timely physician skilled LOC certification, or orders to evaluate and treat, and/or clarification order.	
Y	• Modality	
Y	• If Group Therapy, clarification order includes Group therapy. In addition, participants in group must be documented.	

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Therapy - Based On Part A Charts Audited		Comments
Y	• Frequency	
Y	• Duration reasonable to meet resident goals/needs.	
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	• Monthly summary	
Y	Daily encounter note matches therapy service logs.	
Y	Weekly Summary notes by treatment intervention/modality.	
Y	Source document (e.g. therapy services log) for treatment minutes accurate in medical record, to include clinician's signature and initials; individual, concurrent, and group.	
Y	System in place to track Concurrent or Group minutes, if needed.	
Y	Systems in place to monitor COT rolling observation periods.	
Y	Actual minutes are usually coded without a pattern of rounding.	
Y	Actual (total) minutes are provided to MDS Nurse.	
Y	Physician approval of significant changes in treatment plan.	
Y	Physician orders for skilled services.	

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Therapy - Based On Part A Charts Audited	Comments
Recommendations	
• None	

Part B Therapy Documentation		
Y	Nursing documentation of decline, prior to initiation of Medicare Part B services, to justify medical necessity.	
Y	Business office ensures a Medicare as Secondary Payer form is completed each time Part B is initiated.	
Y	Physician's orders for evaluation and treatment as indicated.	
Y	Once order is obtained, timely referral to therapy for an evaluation per facility policy.	
Y	Clarification order includes modality, frequency, duration, and type of therapy using CPT coding terminology per policy.	
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	

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Part B Therapy Documentation		
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 with daily encounter note includes the following required elements: ** Note some MAC may require a daily narrative, not just a grid.*	
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. usually by 10th visit note, or change in status resulting in change in POT)	
Y	• Physician signature is only required if a recertification is indicated or if there is a resident status change resulting in a change in overall POT and/or long term goals.	

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Part B Therapy Documentation		
Y	• Modality	
Y	• Frequency	
Y	• Duration based on resident needs.	
Y	• Measurable and time limited goal	
Y	• Medical Diagnosis and Treatment Diagnosis	
Y	• Onset Date	
Y	Progress Note noted at least after every 10 treatment days; weekly summaries meet this requirement.	
Y	System in place to apply G Code measurements.	

Recommendations:

- None.

UB-04 Compliance - Based On UB-04s Audited for Part A and B		Comments
Y	UB-04 coding accurate (Bill type, days, etc).	
N	• Bill type appropriate for resident current status	Medicare Part B claim with a TOB of 223 with SOC and EOC in the same month, correct TOB would be 221.
Y	• Days billed for 5, 14, 30-Day MDS including COT, EOT, or EOT-R OMRAs meets PPS day requirements	
Y	• Billed day count accurate not including day of discharge	
N	• Are charges listed appropriately on UB-04? (Proper charge coding, actual charges when per-diem contracts are in place)	Total treatment units provided for Medicare Part A claims.

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UB-04 Compliance - Based On UB-04s Audited for Part A and B		Comments
N	• Diagnosis coding on UB-04 is justified in corresponding medical record and pertinent to this resident stay.	
Y	• Principle/Primary and those diagnoses following support therapy as a skilled service, and/or supports need for continued skilled care.	
N	• Admitting diagnosis is the reason the beneficiary was admitted to the SNF for Part A level of care, and relates to the current acute admission i.e., "after care code".	The admitting diagnosis codes on the charts audited indicated V57.89.
Y	• Evidence of facility following Consolidated Billing Regulations	
Y	Does coding on MDS ARD and MDS reasons match the UB-04 Occurrence Code 50 dates and modifiers?	
Y	Method or procedure in place to capture and inform vendors of Medicare payment status.	
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, including drop in skilled status if applicable.	
Y	Correct use of G codes on claims.	

Recommendations

- V57.89 should not be used as an admitting diagnosis code. The admitting diagnosis should be the medical reason the resident was admitted. Proper sequencing of primary and secondary codes should support the need for therapy level of care. Recommend the facility contact Net Solutions software to add the admitting diagnosis on the claim, and proper sequencing.

Communication with Billing		Comments
Y	Evidence of communication of required information to billing as part of daily	

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Communication with Billing		Comments
	and weekly Medicare meetings especially related to OMRA MDS (COT, EOT, EOT-R) to ensure accurate census figures, RUG levels, and pay types.	
Y	ICD-9 coding is accurate and communicated to billing; ICD-9 codes removed when resolved.	
Y	Monthly Triple Check in place to ensure accurate billing.	
Y	MDS Nurse shares Validation Report with Billing.	

Recommendations

- None.

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

SERVICES AVAILABLE AS PART OF YOUR REHABCARE CONTRACT

- ☐ **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**
- ☐ **MDS 3.0 Quality Measures Review**
- ☐ **5 Star Analysis**
- ☐ **NY CMI Review**
- ☐ **TX CMI Review**
- ☐ **PA CMI Review**
- ☐ **Medicare Billing Audit and RAC Readiness Review**
- ☐ **Census Development**
- ☐ **Ancillary Cost Management**
- ☐ **Quality Improvement (QAPI) 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**

In addition to the services currently provided within the RehabPlus contract,
the following Polaris Group services are available by separate Letter of Agreement:

- ☐ **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**
- ☐ **Key Indicator Trends (KIT reports)**
- ☐ **Supervisory Skill Training and Team Building, designed to decrease turnover Live Webinar 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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