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NEWS & VIEWS

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The Medicare Triple Check Process—Only as Effective as Its Weakest Link

By: Louise Lindsey

Most people today are familiar with the saying: “A Chain is Only as Strong as Its Weakest Link.” Generally, this idiom is interpreted to mean that a group or organization can only be as successful as its least successful or powerful person. The success of the entire group is dependent upon the success of each individual member of the group. If one person fails, the whole group fails.

This concept is especially valid when implementing the Medicare Triple Check Process to systematically verify the accuracy of data prior to submission of claims to the fiscal intermediary under the Patient Driven Payment Model (PDPM).

The PDPM became effective October 1, 2019, with the purpose of enhancing how payments are made under the skilled nursing facility (SNF) prospective payment system (PPS) as follows:

- Improving payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided.
- Significantly reducing administrative burden on providers.
- Improving SNF payments to underserved beneficiaries without increasing total Medicare payments.

There are five case-mix adjusted components to PDPM which are all based on data-driven, stakeholder-vetted patient characteristics. They are as follows: 1) Physical Therapy (PT); 2) Occupational Therapy (OT); 3) Speech Language Pathology (SLP); 4) Nursing; and 5) Non-Therapy Ancillary (NTA). A “Variable Per Diem (VPD) adjustment” is also included for adjusting the per diem rate over the course of a resident’s stay.

The changes involved in the transition from the Resource Utilization Group, Version IV (RUG-IV) to PDPM significantly impacted PPS for SNFs. Where RUG-IV reduced everything about a patient to a single, mostly volume-driven case-mix group, PDPM focuses on the unique individualized needs, functional characteristics, and goals of each patient. By addressing each individual’s unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven care model. However, these are significant changes in determining Medicare reimbursements that make having a Medicare Triple Check Process with no breakdowns essential for accomplishing the following PDPM goals:

- Ensuring accuracy of billing for skilled services

- Preventing submission of false claims
- Reducing the number of adjusted or denied claims
- Determining that residents receive the benefits to which they are entitled
- Ensuring that clinical documentation correlates with financial data

Medicare Triple Check Process Representatives' Responsibilities

The Medicare Triple Check Process involves representatives with specific responsibilities from these areas: Business Office; Therapy Department; Nursing Department; MDS Coordinator; DON, ADON, or designated Clinical Manager; and Administrator, Chief Financial Officer, or Chief Operating Officer.

The **Business Office** must investigate and verify the following:

- Resident has Medicare benefit days available
- Qualifying stay listed on UB-04 corresponds with medical record dates
- Census log admit date agrees with the UB-04 date
- Resident's name, social security number, and Medicare numbers
- Timeliness of the NOMNC letter
- Confirm that vendors do not bill Medicare directly for items included in the facility's required Medicare A consolidated billing, e.g., laboratory, radiology, pharmacy, and equipment
- Medicare Secondary Payer (MSP) is signed and dated as appropriate

The **Therapy Department** must verify that all therapy minutes recorded in the daily treatment grid agree with the service log for all therapy disciplines:

- Days and minutes recorded on the MDS correspond with the treatment grid
- Principle and secondary diagnoses related to skilled care are listed accurately
- Number of units billed on the UB-04 correspond to the therapy service log

Nursing Department must either verify or ensure the following:

- Verify that documentation supports Medicare skilled interventions during dates of service which correspond with the census log
- Ensure that the physician certification/recertification form is completed and signed by the ordering physician
- Verify that physician orders are received and implemented
- Ensure that charting is completed at least once every 24 hours to support the skilled service being received, including charting that supports therapy or other skilled services

MDS Coordinator must do the following:

- Validate that the PDPM level of each MDS agrees with the UB-04
- Verify that the MDS assessment type agrees with the UB-04
- Confirm that ADLs are correctly entered and supported by documentation
- Ensure that Section GG Functional Abilities and Goals accurately depicts each resident's performance
- Corroborate that all contributary items/interviews are coded
- Substantiate that ICD-10 codes are correct and correspond to diagnoses
- Determine that every MDS used in the process corresponds to a validation report received from the MDS repository

Administrator/CFO/ COO responsibilities involve:

- Chairing the Medicare Triple Check Meeting
- Ensuring that all participant responsibilities are completed prior to Medicare claims submission
- Monitoring the effectiveness of the interdisciplinary team interactions
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When viewing the responsibilities for each area in the Medicare Triple Check Process, there are some items to note that must agree—MDS Assessment data; daily skilled nursing and rehab services; billing dates; UB-04 data to include admission and discharge dates, and occurrence dates; assessment reference dates; leave of absence dates (if any); and hospital stay dates.

During the actual Triple Check meeting, time should be spent verifying and cross-checking each Medicare claim, and any final verifications and cross-checks should be completed by someone other than the person who originally recorded the information being confirmed. Concerns have been identified related to therapy usage decline in some nursing homes after the implementation of PDPM, with its reduced focus on therapy services and increased awareness of resident individualized functional needs. Facilities must ensure that all residents who need therapy services receive the level that meets their actual medical necessity.

The Medicare Triple Check process provides substantial protection against the submission of false claims; however, some false claims still occur.

False claims violations have come from:

- Upcoding PDPM Categories to capture a higher rate of reimbursement than was provided
- Billing for “unnecessary services” that were delivered to residents
- Billing for services not delivered to the resident as claimed
- Billing for individual therapy when group therapy was provided
- Lack of supporting documentation for the MDS
- Inaccurate MDS completion

False Claims Audit and Reporting Guidelines include the following:

- 6-year look back period
- Accurate and diligent facility auditing
- Reporting within 60 days after initial identifying of an error and completing full identification.
- Investigation into full identification must take no more than 6 months.
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Ensuring that there are no breaks at any stage of the Medicare Triple Check Process, is the key to secure, effective, accurate Medicare reimbursement.

New NAB/NCERS Approved Privacy Series Course Now Available

The Privacy Management for Post -Acute Healthcare Professional Series is designed to provide a policy focused framework for leaders in post-acute healthcare settings.

This series will help leaders to plan, implement and evaluate privacy practices consistent with laws, regulations and best practices. It is intended for administrators, directors, officers, clinical staff, employees, contractors, consultants and others working in the post-acute care setting.

The course consists of 4 modules. Each module includes a post-test. The program is approved for 2.25 CEs from NAB/NCERS. A combined minimum passing percent of 70% for all post-tests is required to earn the 2.25 CEs.

For full details please click on this link:
https://mednetcompliance.com/store/product/nab-ncers-approved-privacy-series-course/

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compliance@mednetconcepts.com