FREE WEBINAR

TRANSFORMING TRIPLE-CHECK

How to turn denials into dollars

THU, NOV 9 | 1:30 PM CT

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AGENDA

Overview of today's discussion

- How Triple-Check can make or break your facility
- Roles and responsibilities of Triple-Check team members
- How to run effective Triple-Check meetings
- Best Practices from beginning (preadmission) to end (claim payment)
- How to take your Triple-Check process to the next level
- Q&A

POLL #1

What does FCA stand for?

A. Fantastic Care Award

B. Freedom Choice Action

C. False Claims Act

How Triple-Check can make or break your facility

False Claims Act (FCA)

Recently, in a Skilled Nursing News Article, Mark Reagan, General Counsel for ACHA, states "Under the FCA (False Claims Act), skilled nursing facilities can be held liable for submitting false or fraudulent claims for payment from government programs, like the 1135 waivers implemented during COVID. The waivers allowed SNFs to admit Medicare Part A covered patients without the usual requirement of a three-day qualifying inpatient stay. Reagan said he expects to see investigations regarding whether all patients classified as needing skilled care under these waivers were truly appropriate for such care.

Medicare Targeted Probe and Educate (TPE)

If FCA wasn't scary enough, on June 5, 2023, Medicare also initiated a new 5 claim Probe and Educate review for all Skilled Nursing Facilities. A Medicare Targeted Probe and Educate (TPE) is an overwhelming, costly, and burdensome process for any SNF. Your initial claim and future claim payments are suspended for the entire duration of the TPE. It is a prepayment probe that can hold up cash flow for months. Ultimately, if through the review process your accuracy does not improve, you are subject to referral to CMS for next steps that can include a 100% prepayment review, extrapolation, Recovery Audit Referral, or "other action".

Reducing your risk potential

Every facility must have a measurement of adherence to billing accuracy. A proper Triple-Check process is the basis to being compliant, reducing billing mistakes and irregularities, self-identifying errors, and finding potential areas of risk.

POLL #2

How many years do you need to keep Medicare Secondary Payer (MSP) forms on file?

A. 5 years

B. 10 years

C. 15 years

Rolls & responsibilities of Triple-Check team members

Roles & responsibilities of Triple-Check team members (SAMPLE)

Reponsibilities by Position		Worksheet should be created by the end of the second business day following the month end. Tasks that need to be done prior to internal triple check can be marked off on worksheet with everything completed and reviewed during final IDT team triple check.		*= done prior to internal TC		*= reviewed at Final Triple Check (MDS, Therapy, Clinical/DON & Biller - team members to be present)
MDS	**Therapy**	**Clinical/DON**	**Biller**	**Med Records**	**Admissions**	**Social Services**
MDS accepted into QIES	Therapy Evaluation, Plan of Care, upocs and pocs are loaded in pcc and signed	Ancillary charges verified to be correct and provided to Biller to add to claim- Any extra rentals or charges sent to biller before triple check to add to claim	Beneficiary name and insurance policy number with matching insurance payer (Primary & Secondary)	Physician cert / recert signature is Legible and Dated; if physician signature is not legible – is on a signature form In the facility	MSP form signed - Notify biller of any questions alerted	SNF ABN/NONMC validated (when applicable)
ARD/occurrence code Match	Therapy Reflected correctly on claim	Ancillary charges included on claim (pharmacy, labs, diagnostics, medical supplies and oxygen)	Authorization number if applicable	History & Physical Visit Signed or Progress note when applicable	Consent to Treat	
Days correct each HIPPS (including default and provider liable days) Any IPA are correct and summary documentation present for change	Service dates match number of days	Daily Nursing Documentation for each day	Type of Admission	Signed and dated MD orders present hospital inpatient order, Admit to Treat	Beneficiary name and insurance policy number with matching insurance payer (Primary & Secondary)	
Primary and Supporting Diagnoses correct & Supported	Service dates match number of days		Condition Code	Physician Name and NPI	Authorization number if applicable	
Daily Nursing Documentation for each day	ARD & Days correct each HIPPS (including default and provider liable days) Any IPA are correct		Occurrence Codes		Resident Name Match CWF	
Service dates match number of days			Status Code		Date of birth	
ARD & Days correct each HIPPS (including default and provider liable days) Any IPA are correct			Type of Bill		Gender	
			Value Codes - Admissions enter days used prior		Admission Date, Payer Charges, Discharge date, DC Status	
			Revenue Codes		Hospital Stay Dates/ Admission Source	
			ARD & Days correct each HIPPS (including default and provider liable days) Any IPA are correct			
			Service dates match number of days			

Business Office or Designee

- Verifying via the Common Working File that the resident has Medicare benefit days available
- All resident names, date of birth, gender and Medicare Beneficiary numbers are accurate and verified
- The Medicare Secondary Payer (MSP) form is signed and dated, as appropriate. (MSP forms are required to be kept on file for 10 years)
- Consent to treat is completed
- All qualifying stays listed on the uniform billing form (UB-04) correspond with medical record dates
- Census data from EMR agrees with all entries on the UB-04
- The Notice of Medicare Non-Coverage (NONMC) letter submission is timely and complete
- Vendors do not bill Medicare directly for items included in the facility required Medicare A consolidated billing, such as laboratory, radiology, pharmacy, therapy, and equipment
- No claims are submitted for working age Medicare beneficiaries who are covered by an Employer Group Health Plan or other insurance

Therapy Department

- Verifying that all therapy minutes recorded in the daily treatment grid agree with the service log for all therapy disciplines
- Ensuring that all days and minutes recorded on the MDS correspond with the treatment grid
- Ensuring that principle and secondary diagnosis related to skilled care are listed accurately
- Ensuring that the number of units billed on the UB-04 correspond to the therapy services log
- Therapy Evaluation, Plan of Care (POC) and Updated Plan of Care (UPOCS) are loaded in EMR record and signed

Director of Nursing/Clinical

- Daily Nursing Documentation to support skilled care
- Ancillary charges verified to be correct and provided to Biller to add to claim
- Ancillary charges included on claim (pharmacy, labs, diagnostics, medical supplies, equipment, and oxygen)

Nursing Department

- Verifying that all documentation supports Medicare skilled interventions during dates of service which correspond with the skilled census
- Ensuring that the physician certification/recertification form is completed timely and appropriately, includes description of skilled services, and is signed and dated by the ordering physician
- Verifying that physician orders are received and implemented
- Ensuring that charting is completed at least once every 24 hours to support the skilled services being received, including charting that supports therapy services

MDS Nurse/ Coordinator

- Validation that the Patient Driven Payment Model (PDPM) level of each MDS agrees with the UB-04, including the Assessment Reference Date (ARD)
- Verification the MDS assessment type agrees with the UB-04
- Primary Diagnosis in Field 67 on UB-04 matches the diagnosis in the MDS field I0020B and is not on the Return to Provider List
- Confirmation that the Activities of Daily Living (ADLs) are correctly entered and supported by documentation
- Ensure that Section GG Functional Abilities and Goals accurately depicts each resident performance
- Primary and Supporting Diagnoses correct, supported, and properly sequenced.
- Corroborating that all contributory items/interviews are coded
- Substantiating that all Internal Classification of Diseases, 10th edition (ICD-10) codes are correct and correspond to diagnosis
- MDS accepted into iQIES system
- Discharge summary completed upon discharge from skilled stay

Administrator/ Executive Director

- Ensures the meeting occurs monthly prior to claims submission, and that all required attendees/disciplines are present, on time, and prepared
- Keeps the meeting focused and on task

How to run an effective Triple-Check meeting

Key Elements

Time

Target a set date/time and adjust if necessary

Arrive prepared and on time – the meeting is not the place to correct or search for missing items/documents

Remain Focused and stay on task

Train Back Ups – always have a plan B

Deliverables

Allow adequate time to review all claims

Select your date to submit and receive payment in the current month- remember to account for federal holidays

Communicate in advance with vendors to ensure ancillary bills are received timely

Look at timing of MDS transmissions related to timing of claims submissions and the Triple-Check process

If something is not in place or needs to be fixed – add it to a follow up list and assign responsibility

See Exhibit B - Sample of Triple-Check Hold Tracking Tool

Review status of outstanding items at daily standup or daily/weekly skilled meeting

Everyone's input and time is valuable.

Bench strength is important so that if a key team member is out unexpectedly you remain on schedule and avoid cash flow interruptions

Best practices:

From beginning (pre-admission) to end (claim payment)

Best practices from beginning (preadmission) to end (claim payment)

Pre-admission

- Before a patient's admission, it is crucial to verify their insurance eligibility and coverage
- Confirm the patient's demographic information from referral matches patient eligibility check
- Verify the Qualifying Hospital Stay meets the required three consecutive midnights inpatient stay or if an authorization is required
- Orders signed and dated: MD, hospital inpatient order, Admit to Treat

Admission

- Admission entry: Patient Name, Date of Birth & Gender, Admission date, QHS, Admission source, Physician Name , NPI, and taxonomy code, Insurance policy number(s) with matching insurance payer (Primary & Secondary)
- Completion of forms for: MSP, consent to treat and consent to bill
- Authorization obtained when applicable
- Physician cert / recert signature is Legible and Dated; if physician signature is not legible – is on a signature form in the facility
- History & physical visit signed, or progress note when applicable
- MDS nurse will review forwarded hospital records, testing results and any other documentation to start an accurate profile of the new admission
- Care plans and assessments started by IDT team
- Section K (Nutrition) of MDS reviewed and captured when applicable

Best practices (continued)

During skilled stay – daily and/or weekly

- Confirm diagnosis: principle, admission, sequencing correct. Therapy diagnoses are included for each discipline
- Strong review of all new admission and clinical details daily up to the 5-day ARD and/or IPA
- Confirm Therapy and Nursing Section GG Information daily/weekly
- Monitor regularly for conditions that warrant an IPA
- Weekly Medicare meetings held to review all current data and ensure IDT team has provided their information and there is not any conflicting ADL data between the team
- MDS is completed and submitted to iQIES
- Discharge planning and NONMC presented two days prior to skilled services ending

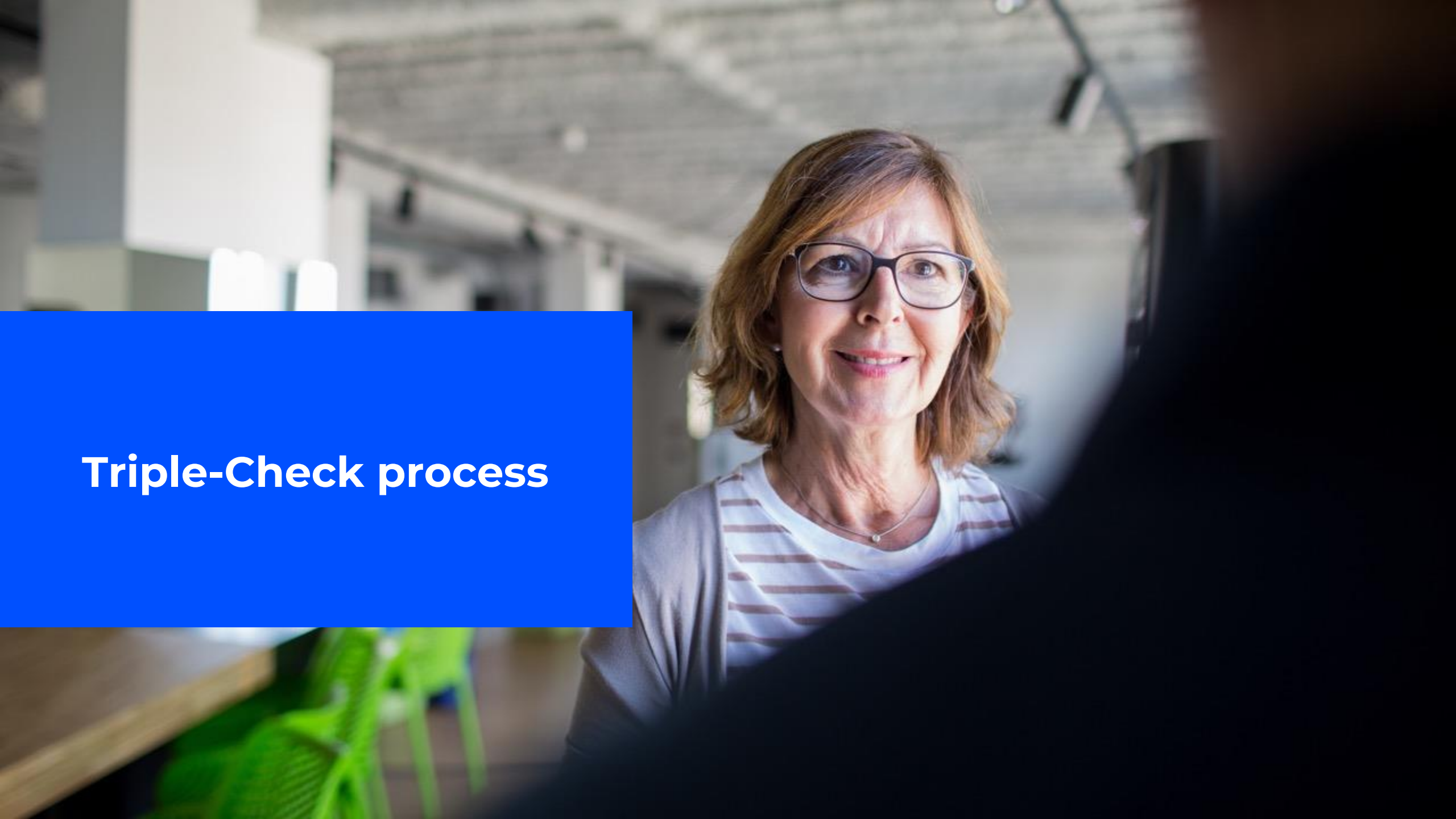
POLL #3

What is the national average for initial claim denial rate as a percentage of claim volume?

A. 1 %

B. 2%

C. 8%



Triple-Check process

Monthly Triple-Check
Some data and documents should be reviewed prior to full IDT final Triple-Check

MDS, Clinical Team and Therapy – Review the following:

1. Physician cert / recert signature completed and includes description of skilled services. Must be legible and dated; if physician signature is not legible –signature form is required to be kept at facility
2. Signed POC and UPOC orders
3. MDS accepted into iQIES
4. ARD/Occurrence codes match
5. HIPPS Code matches and Days correct for each HIPPS (including default and provider liable days) between MDS and Therapy
6. PT,OT and ST visits are correct
7. Primary and Supporting Diagnoses present & supported
8. Ancillary charges validated, and invoices given to Biller or appropriate person (pharmacy, labs, diagnostics, medical supplies, and oxygen)

Monthly Triple-Check
Some data and documents should be reviewed prior to full IDT final Triple-Check

Business Office/Admissions/Social Work - review the following:

1. Review of name, date of birth, gender, confirm admission date and source, hospital stay dates, payer source/insurances, authorization obtained and entered in EMR when applicable, facility NPI, physician name and NPI
2. Confirm Consent to Treat and MSP forms are completed and signed
3. If SNF ABN and/or NONMC was issued; is census correct based on last covered skilled day on NONMC
4. Discharge/status code correct

Final review process with IDT Team

Monthly Triple-Check
Full IDT Team Triple-Check Review

Business Office/Clinical (MDS)/Therapy/Administrator (periodically)/Director of Nursing or Designee:

Best Practice Recommendations

All Medicare and Managed Care Skilled claims should be reviewed.

A sign in sheet should be used and all documentation and logs from Triple-Check Meeting should be kept together as verification and support of the Triple-Check completion.

Utilization of a Triple-Check worksheet is recommended to validate all aspects of the claims review were complete.

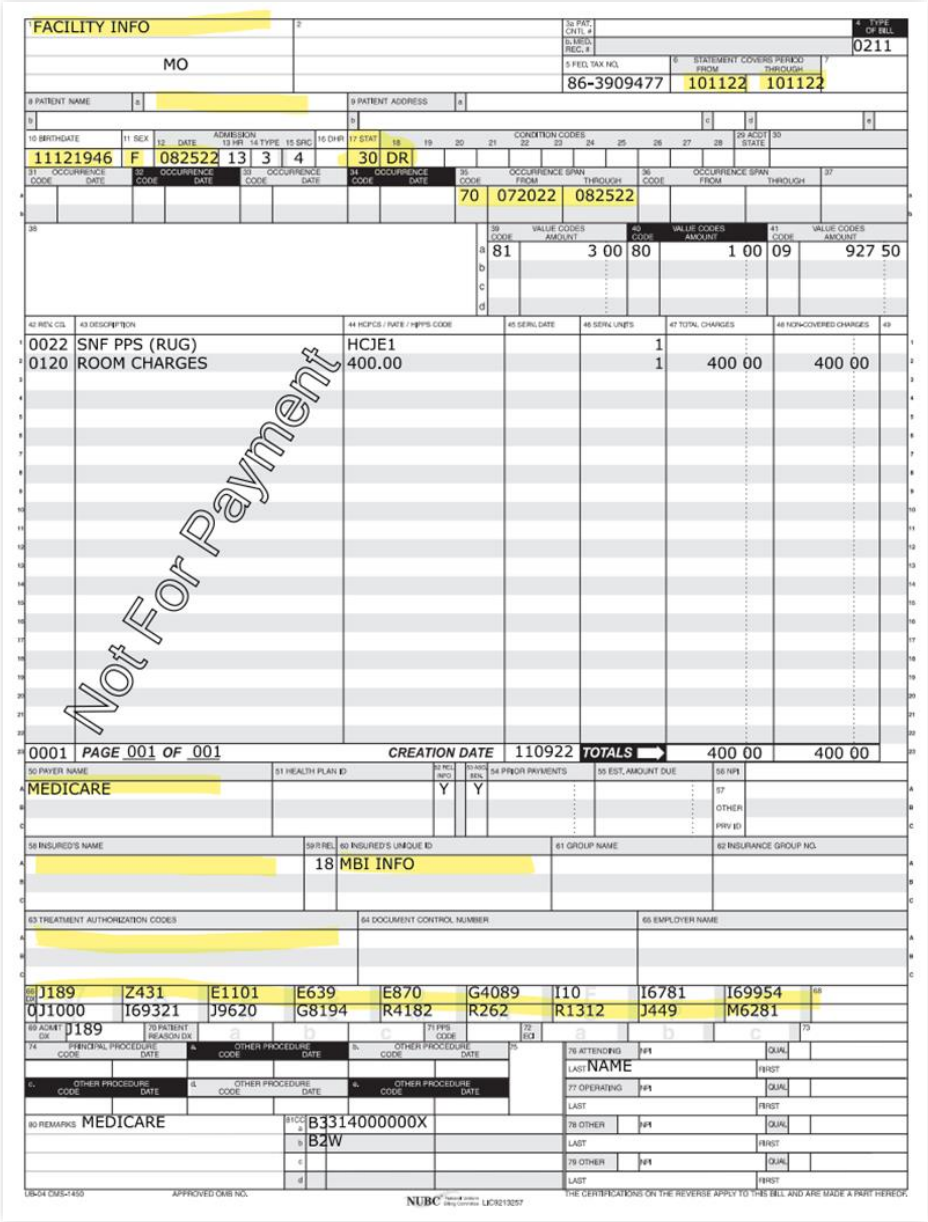
Sample Triple-Check worksheet

	Patient Name				
Responsible Person(s)	Billing Verification Part A:/Done Prior to Triple Check with MDS,Therapy, Clinical team				
Clinical/DON	Ancillary charges verified to be correct and provided to Biller to add to claim- Any extra rentals or charges sent to biller before triple check to add to claim	X			
HID	Physician cert / recert signature is Legible and Dated; if physician signature is not legible – is on a signature form In the facility	X			
HID	History & Physical Visit Signed or Progress note when applicable	X			
HID	Signed and dated MD orders present hospital inpatient order, Admit to Treat	X			
MDS/DON	Daily Nursing Documentation for each day	X			
MDS	MDS accepted into QIES	X			
MDS	MDS Tool complete and sent to biler	X			
MDS	ARD/occurrence code Match				
MDS	Days correct each HIPPS (including default				
MDS	Primary and Supporting Diagnoses correct & Supported				
Therapy	PT, OT, ST visits are correct with matching	x			

Triple-Check review with IDT team

1. Business Office or Designee will also walk through the UB04 claims and all team members will acknowledge the information is correct for each Medicare and Managed Care A claim.
    - Type of bill
    - Dates of Service
    - Date of Birth
    - Gender
    - Admit From
    - Status Code
    - Last covered day (if applicable)
    - Assessment/ARD Date
    - Hospital stay dates
    - Interrupted stay dates (if applicable)
    - HIPPS and number of days billed for each MDS correct
    - Ancillaries noted
    - PT, OT, ST visits are correct
    - Payers correct – Primary and Secondary
    - Authorization on claim when applicable
    - Diagnosis for both skilled services and therapy services noted and appropriate
    - If active HIV/AIDS ICD10 Code B20 is present on UB04
    - Physician name and NPI
2. Any holds should be documented and tracked. A tracking tool with assigned responsibility is highly recommended.
3. Once the MDS and/or corrections have been resolved, immediate notification will be sent to the Biller or designee who then will release the claim(s).

UB04



TC hold tracking tool

Facility:	SNF				
Medicare A	Date of Triple Check:				
Month:					
Resident Name	Dates of Service	$$ Amount of Claim	Problem	Department Responsible	Date Final Triple Check Completed

Monthly billing

- After final IDT Triple-Check has been completed, all claims that have been identified as accurate and compliant can be released to appropriate payers
- Biller or Designee should follow up with payer after 48 hours to review and work any claims that have been denied, returned to provider, or rejected
- Any held claims will need to be identified as complete and accurate and then released to the appropriate payer

Claim payment

- Upon receipt of ERA, posting of payment will require detail review. Any patient responsibility should be verified and matched to either private pay balance or secondary payer balance
- Any contractual adjustments such as sequestration should also be reviewed and ensure that payer is set up correctly reflecting the correct percentage
- Medicare variances are usually minimal due to penny rounding variances and usually a couple of dollars or less. If you have payment(s) that result in larger variances, review of payer rules and rates, VBP and Wage Index should be completed to find the root cause

How to take your Triple-Check process to the next level

Getting Started

Do not let the process overwhelm you. Remember that the Triple-Check is a final review of all the things you've already done through the skilled stay – from preadmission to claim preparation.

Allow time to grow. Your first meeting will take a bit longer, but you will find ways to become more efficient.

Consider scheduling more than one meeting to start – review Medicare Part A and Part B at one meeting, Managed Care A and Part B at the second meeting.

How to Improve

Use the status of claims to improve your process through Interdisciplinary Team discussion.

- If a claim denies, rejects or falls to technical status, review your Triple-Check and identify where or what process could have prevented the payment delay
  - Was something overlooked or is there an item of review that needs to be added or changed?

How to Improve

Become Visual – LOOK at the data you are verifying

- Eyes on the items or documents you are validating, consider cross discipline review, identify EMR software or vendor reports that will make the review easier

Remember to include and review of any negotiated outliers or Letters of Agreement

- Make sure you are not leaving money on the table because an outliner, negotiated rate, or ancillary item is not billed properly

If an Item needs to be corrected, remember to fix it at the source – don't just update the UB04 claim document.

Where do you keep your documents? Many review requests come months or even years after the care was provided. Make sure key information is a part of your Electronic Medical Record.

Other Reminders

Minimum weekly review of those residents that come off skilled care with benefit days remaining, remain in your facility, and are in their 30-day window for any change in condition that would make them eligible for skilled coverage.

Review those residents that exhausted benefits and remain in your facility for any change that would start their spell of wellness (60-day break)

- Notify your Billing Office of this change in care level so that appropriate informational claims can be submitted to Medicare to start the count in the 60-day break

Other Reminders

Run a new eligibility check monthly to validate there are no surprises.

- Benefit days remaining match what you have in your EMR record
- No changes to the primary payer (Monitor for enrollment into Managed Medicare Plans or other plans)

Review the PDPM scores provided by third parties – was all pertinent information provided when they assigned the PDPM score?

Final thoughts

How can you ensue billing accuracy is 100% compliant? Get started on improving your current process today.

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Don’t hesitate to contact one of us by email or phone.

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Questions?

Thanks for joining us!

Webinar recording and slides will be available here

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References

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