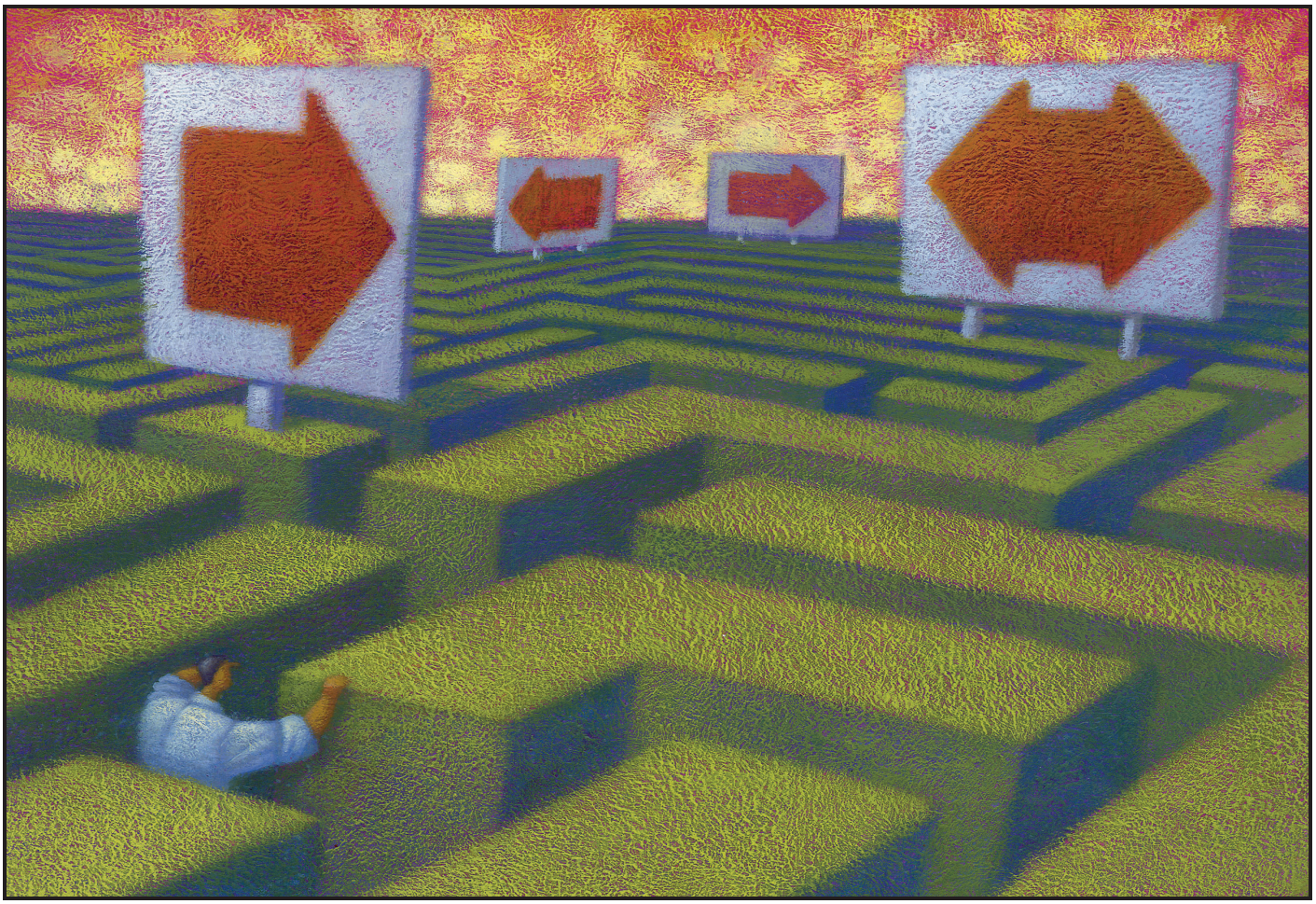

Issues, Ideas & Actions

Useful information from Ryun, Givens & Company

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Ryun, Givens & Company, P.L.C.

Keys to Compliance

Every year, the U.S. Office of Inspector General (OIG) identifies government programs under the Department of Health and Human Services that are vulnerable to waste and abuse through erroneous claims.

In 2009, the OIG's work plan called for auditing a sample of Medicare claims submitted by skilled nursing facilities (SNF). The goal was to determine the accuracy of coding for resource utilization group (RUG) claims, and claims for services under Part B during a Part A SNF covered stay, They were also checking on the calculation of Medicare days as it relates to no-pay bills and Minimum Data Set (MDS) accuracy.

Today, there are many Medicare audit programs designed to address these issues, including the following:

- CERT - Comprehensive Error Rate Testing
- RAC - Recovery Audit Contractors
- Medicare Medical Review Program

The January 10th, 2014 issue of MCA Monthly (www.midwestcomplianceassociates.com), says it pretty well:

"As the party signing the request for payment, the provider has the affirmative duty to assure the billing being submitted is accurate and based on proper documentation. Submission of false or inaccurate billing can lead to very serious issues such as requests for recoupment or even worse, an action under the False Claims Act. Providers are encouraged to work with a knowledgeable professional to develop a protocol for auditing their billing software to assure information is being processed correctly, that an audit trail exists and that bills will not be submitted for payment without proper supporting documentation. In an age where we believe just about anything we see digitally, it is even more important to circle back and make sure the billing software is processing information correctly and that providers be able to show they have exhibited due diligence in assuring the accuracy of billing."

Since Ryun, Givens and Company, P.L.C. is NOT an expert in Medicare Billing, we strongly recommend that you consult with Medicare billing and compliance experts for any questions you may have. We are familiar with several excellent providers of this service, and would be happy to give you references, at your request.

On the next two pages, we have compiled a comprehensive list of crosschecks and controls that your organization may find helpful in ensuring proper due diligence, and to make sure that your billing is accurate and based on proper documentation. A good system has more than one individual involved. Also, the preparer/originator's work needs to be checked and crosschecked by someone other than the preparer/originator. The following lists of crosschecks and controls gives examples of what needs to be done, and who could be verifying this work.

Please feel free to call Whitney at (515) 225-3141 or contact us at sgivens@ryungivens.com.

Crosschecks & Controls

Medicare Part A

Business Office Manager and Medical Records:

Verify qualifying stay on UB-04 to medical records face sheet

Business Office Manager:

Verify that resident has benefit days available per the HETS

Verify admit date on UB-04 agrees with manual census log

Verify covered service dates on UB-04 agree with Medicare log and manual census log

Verify that there is a signed and completed MSP form in patient's financial file

Business Office Manager and MDS Coordinator:

Verify activities of daily living (ADL) are correct and supported by documentation and other contributory items are coded (e.g., mood, Is)

Verify that each of the MDS used in following checks agrees with validation report received from the state repository

Verify that ARDs per each MDS agree with UB-04 FL 31-34

Verify that RUG level per each MDS agrees with UB-04 FL 44

Verify that assessment type for each MDS agrees with modifier on UB-04 FL 44

Verify that number of accommodation units on UB-04 agrees with assessment type for each MDS

Verify that the total number of accommodation units agrees with covered service dates

Facility Rehab Director, MDS Coordinator, and Business Office Manager:

Verify that physical therapy minutes per the daily treatment grid agree with service log

Agree days and minutes per the MDS with the treatment grid

Agree number of units billed on the UB-04 with the service log

Verify principle diagnosis is accurate, secondary diagnoses all support skilled care, and ICD-9 codes correspond to the diagnoses

Verify that occupational therapy minutes per the daily treatment grid agree with service log

Agree days and minutes per the MDS with the treatment grid

Agree number of units billed on the UB-04 with the service log

Verify that speech therapy minutes per the daily treatment grid agree with the service log

Agree days and minutes per the MDS with the treatment grid

Agree number of units billed on the UB-04 with the service log

Verify correct G codes for Part B claims

Director of Nursing and Medical Records:

Verify that resident required Medicare skilled intervention through supporting clinical documentation during dates of service per the manual census log

Verify that physician certification/recertification form has been completed and signed by physician

Verify that physician orders have been obtained and implemented

Verify that charting guidelines are in the chart, charting is completed at least one time in every 24 hour period, charting related to the skilled services being provided, and charting supports therapy services

Facility Rehab Director:

Verify that rehabilitation services are stated on physician orders

Verify that evaluation includes prior level of function

Verify that clinical documentation states progress noted warranting continued skilled intervention

Administrator:

Ensure that the above process is completed by the facility each month prior to Medicare claims being submitted to the Fiscal Intermediary

Participation in this process will allow the administrator to monitor communication effectiveness of facility processes between the interdisciplinary team

Crosschecks & Controls

Medicare Part B

Business Office Manager and Medical Records:

Verify that principle diagnosis code on UB-04 FL and diagnosis sequencing on UB-04 FL agree with medical records face sheet

Business Office Manager:

Verify covered service dates on UB-04 agree with dates of service that are being billed and match census covered days

Verify that the patient financial file has a completed and signed MSP form

Business Office Manager & Central Supply:

Verify that all appropriate ancillary charges are reflected on UB-04. Ancillary charge may include the following:

- surgical dressing supplies
- urologicals
- prosthetic devices (e.g., catheter, colostomy supplies)
- laboratory
- radiology

Business Office Manager & Facility Rehab Director:

Verify that the Healthcare Common Procedures Coding System (HCPCS) code UB-04 matches the HCPCS procedure performed per log or grid

Verify that the modifiers (GO, GP, GN, KX, 59) on the UB-04 correctly match the treating therapy, therapy cap limits, and National Correct Coding Initiative (NCCI) edits

Verify that the number of minutes and units on the UB-04 correctly matches the therapy log and grid

Verify that the occurrence codes on the UB-04 FL correctly describe the current patient service dates

Verify that the value codes on the UB-04 are correctly coded and summed

Verify that the revenue codes on the UB-04 are correctly coded for the type of procedure or supply being billed

Business Office Manager & Director of Nursing:

Verify that the certification and recertification have been signed and completed by the attending physician according to Medicare guidelines

Verify that all orders and clarification orders have been written and signed by the attending physician for all services being billed

Facility Rehab Director:

Verify that rehabilitation services are stated on physician orders

Verify that evaluation includes prior level of function

Verify that clinical documentation states progress noted warranting continued skilled intervention

Administrator:

Ensure that the above process is completed by the facility each month prior to Medicare claims being submitted to the Fiscal Intermediary

Participation in this process will allow the administrator to monitor communication effectiveness of facility processes between the interdisciplinary team

Please feel free to call Whitney at (515) 225 3141 or contact us at sgivens@ryungivens.com with any questions.

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