HCCA Immersion Session
Internal Auditing

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Objectives

- Define Billing Risk areas as identified by the OIG
- Discuss Sample Concurrent Internal Audit System
- Describe measures to avoid most common MDS coding errors
- State 3 key pieces of information that the clinical staff must provide to the billing office to foster accurate UB-92 claims
OIG Key Billing Risk Areas

- Billing for Items or Services not rendered or provided as claimed.
- Billing for Medically Unnecessary Items
- Duplicate Billing
- Credit Balances
- Upcoding
Other Risk Areas

- Submitting claims for residents who are not eligible
- Knowingly billing for inadequate or substandard care
- Providing misleading information about a resident’s medical condition on the MDS
- Billing for items or services when they are included in the facility’s per diem rate—Unbundling
- Forging physician or beneficiary signatures on documents to verify that services were ordered and/or provided.
Risk Areas Continued

- Failure to maintain sufficient documentation to establish services were ordered and/or performed
- Failure to meet the requirement that a SNF stay be preceded by an inpatient hospital stay of at least three days or a hospital discharge within 30 days of SNF admission
Possible Errors in Practice

- Technical Errors
- Process Errors
- Documentation Errors
Technical Errors

Possible Errors:

- Inaccuracy-miscoded modifiers
- Ancillary charge omissions
- Incorrect service dates (ARD)
- Incorrect assignment of covered days to a specific assessment
- Error in billing software linked to MDS Software
Process Errors

- Possible Errors:
  - Incorrectly entering the handwritten MDS into the computer
  - Referencing, signing, or locking the MDS in an untimely fashion
  - Missing the OMRA or SCSA
  - Discovering an error after the MDS is locked
  - Data entry errors, e.g., therapy minutes
Documentation Errors

Possible Errors:
- Non Descriptive progress notes
- Service omissions
- Incorrect scoring of ADL’s
- Inconsistencies between MDS and Clinical notes
Decision Factors for Audits

- Analysis of the baseline audit
- RAI Process deficiencies in recent surveys or complaint investigations
- Recent level of claims review by the fiscal intermediary
- Medicare Part A & Part B Denial History
- Competency and longevity of MDS Staff
- Level of corroboration & collaboration between IDT
Concurrent Auditing

- Purpose: To identify and correct problems before they become trends and before they become significant problems for residents or for the facility.
- Overall Goals: Correct Claims & Competency in implementation of Medicare Regulations
Auditing Goals

- Verify Technical Eligibility
- Confirm MDS Information on the UB-92 is accurate
- Determine whether off-cycle assessments are captured on claim form
- Verify accuracy of HIPPS form
- Validate RUG levels are consistent with therapy ancillaries on claim form
Auditing Goals

- To corroborate accuracy of the therapy minutes that underlie the Rehabilitation RUG categories billed
- Confirm that MDS Assessments are transmitted prior to billing
Triple Check
Concurrent Part A & Part B Audits

- Covenant Care system for IDT approach to Medicare billing
- Facility conducts monthly audit before claims are sent to FI
- Corporate Regional Participation in support of facility management and staff
Company Culture Change

- Periodic audits of claims changed to 100% of claims reviewed
- Facility staff implemented communication systems to prepare for triple check meeting
- Meeting time decreased due to efficiency in preparation
- Increased Competency regarding billing and documentation
- Claims error rate nominal
Medicare Triple Check Audit Tool Part A

- Audit Tool columns cross referenced with procedure for clarification of responsibilities of staff during audit.
- Procedure references field # on UB-92 identify the correct information needed.
Medicare Triple Check Audit Tool
Part B

- Same guidance & processes in place for verification of Part B services to UB-92
External Auditing

- Former CCI IRO- HFS Consultants, Oakland CA. conducts annual audits on retrospective basis utilizing same methodology as CIA requirements.
- Compliance Review Audit provides feedback on retrospective performance of facility.
- Facility recognized at CCI Annual Meeting for 0% error rate.
Lessons Learned

- Staff had varied knowledge regarding Medicare
- Leadership oversight and support invaluable to success
- Sustained improvement through implementation of standards and expectations through employee job descriptions, performance evaluations and recognition of facility success.
Medical Probe Review

- Medical Review Triggers
- Top reasons for denial
- Medical Review Issues for Clinical Services
- Medical Review Issues for Rehab Services
- CERT Process
Resources

- MDS 2.0 Information Site
  www.cms.hhs.gov/medicaid/mds20/
- CMS SNF PPS Site
  www.cms.hhs.gov/providers/snfpps/
- American Association of Nurse Assessment Coordinators
  www.aanac.org
Thank you!