MEDICARE PART A IN HOUSE CLAIMS REVIEW PROCESS

RESIDENT SELECTION FORM

Facility Name_____________________ Facility #_____________

Month Reviewed__________________ Today's Date___________

MEDICAL RECORD NUMBER	RESIDENT'S NAME

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MDS Billing Review

	REASON FOR ASSESSMENT									
1										COMMENTS
2 *Hard copy of the MDS is present in Medical Chart*										
3 Hard copy signed by all contributing IDT members										
4 ***Section P matches RST Log***										
5 *Assessment Reference Date in AS-400 Matches Assessment Reference Date on Hard Copy MDS*										
6 *Modifier Code corresponds to the Reason For Assessment*										
7 *RUG score on hard copy MDS matches RUG score in AS-400*										
8 *Correct number of days billed for the modifier code that was used*										
9 All Locked MDSs are entered into AS 400 with a RUG score										
10 No Unassigned Days are Present for a locked MDS										
11 *If OMRA/SCSA is done outside an assessment reference window, billing begins on the ARD?*										
12 *If OMRA/SCSA is done within an assessment reference window, billing begins on the ARD or the first day of the billing cycle, whichever is earlier?*										
13 *If coded 08 (OMRA) , no Rehab RUG score is present*										
	YES	**NO**								
14 *Medicare Secondary Payor (MSP) screening form has been completed for initial admission or any readmission that does not occur in the same month as admission.*										
15 *Correct Primary ICD-9 code is entered into S36*										
16 *An OMRA or SCSA is completed if therapy is D/C'd and resident stays on skilled care >10 days*										

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Resident Name ________________________Resident # ______ Month Being Reviewed ___________

Documentation Support Review

	YES	NO	N/A	COMMENTS
1. ***Part A Cert/Recert. Form (BE601C) covers the dates of services under review***				
2. *BE601C is completed with clinical reason for skilled care*				
3. ***All Certs/Recerts are signed by the physician or nurse practitioner***				
4. ***All Certs/Recerts are dated by the physician appropriately: Original cert. Within first 48 hours; first recert by the 14th day of Medicare stay; additional recerts must be made at intervals not to exceed 30 days***				
5. *The quality/content of the documentation in the medical record supports a skilled level of care?*				
2. ***Is there an order for OT?***				
PT?				
ST?				
3. Does nursing documentation correspond/support OT?				
PT?				
ST?				
4. Were there any default days during the month under review. If yes, reasons? a. ARD not adjusted after unplanned d/c b. Missed OMRA c. Wrong reason for Assessment d. No backup for MDS Coordinator e. MDS Coordinator working the floor f. Misidentification of pay type g. Assessment schedule not restarted when resident out over midnight h. ARD not set timely i. Not using Concurrent Review j. Other:				

Perform the MDS Quick Audit to Verify RUG Score on MDS

Resident Name ________________________Resident # ______ Month Being Reviewed ___________

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MDS Quick Audit

Complete the following audit for every MDS being reviewed for the In House Review

RUG Score (from T3)_________________ Assessment Reference Date____________

By reviewing the ADL flowsheet complete the following sections.

<table>
<tr><th colspan="5">SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS</th></tr>
<tr><td>1.</td><td colspan="4">(A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)

0. INDEPENDENT—No help or oversight—OR—Help/oversight provided only 1 or 2 times during last 7 days

1. SUPERVISION –Oversight encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days

2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days

3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
--Weight-bearing support
--Full staff performance during part (but not all) of last 7 days

4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days

8. ACTIVITY DID NOT OCCUR during entire 7 days</td></tr>
<tr><td></td><td colspan="2">(A) ADL SUPPORT PROVIDED –(Code for MOST SUPPORT PROVIDED
OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist 8. ADL activity itself did not
3. Two + persons physical assist occur during entire 7 days</td><td>(A) (B)
SELF-PERF</td><td>SUPPORT</td></tr>
<tr><td>a.</td><td>BED MOBILITY</td><td>How resident moves to and from lying position, turns side to side,
and positions body while in bed</td><td></td><td></td></tr>
<tr><td>b.</td><td>TRANSFER</td><td>How resident moves between surfaces—to/from; bed, chair wheelchair, standing position (EXCLUDE to/from bath/toilet)</td><td></td><td></td></tr>
<tr><td>h.</td><td>EATING</td><td>How resident eats and drinks (regardless of skill). Includes intake
of nourishment by other means (e.g., tube feeding, total parenteral nutrition)</td><td></td><td></td></tr>
<tr><td>i.</td><td>TOILET USE</td><td>How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy
or catheter, adjusts clothes</td><td></td><td></td></tr>
</table>

Does the above match section G of the MDS being reviewed? ___________________

Resident Name _______________________Resident # ______ Month Being Reviewed ___________

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MDS Quick Audit **Continued**

By reviewing the Medical Record and supportive documentation, answer the following questions.

REHAB/EXTENSIVE SERVICES	**Yes**
1. Is the ADL score 7 or greater?	
2. Did the resident receive Suctioning, Tracheostomy Care, Ventilator/respirator treatment or IV Medication in 14 day observation period from the ARD? **OR** Did the resident receive Parenteral feeding in the 7 day observation period from the ARD**?**	
3. Was therapy provided at least 5 times a week for a total of at least 150 minutes? **OR** Was therapy provided at least 3 times a week for a total of at least 45 minutes? Did the resident receive at least two types of Nursing Rehabilitation at least 6 days a week?	
If the answers to all of these questions are YES, did we bill a Rehab/Extensive Services RUG score?	
STOP if answer to the last question was YES, if NO proceed.	

REHABILITATION	**Yes**
1. Was therapy provided at least 5 times a week for a total of at least 150 minutes?	
2. Was therapy provided at least 3 times a week for a total of at least 45 minutes? Did the resident receive at least two types of Nursing Rehabilitation at least 6 days a week?	
If one of the answers to these questions is YES, did we bill a Rehab Rug score?	

STOP if answer to the last question was YES, if NO proceed.

EXTENSIVE SERVICES

Did the Resident receive any of the following during the observation period?	Yes		Yes
14 day observation period:		4. IV Medications	
1. Suctioning		7 day observation period:	
2. Tracheostomy Care		5. Parenteral feeding	
3. Ventilator/respirator treatment			
If one of the about are checked, did we bill a SE RUG score?			

STOP if answer is YES, proceed if answer is NO

SPECIAL CARE

Within the applicable observation period, did the resident have:	Yes		Yes
1. Any items listed above under Extensive Services found in the Medical Record?		7. A feeding tube and Aphasia	
2. Quadriplegia ADL Sum 10+		8. Surgical wounds or open lesions with one of the following wound care or skin care treatments, or foot dressing or special applications, ointments or medications	
3. Multiple Sclerosis and ADL Sum 10+		9. Respiratory Therapy	
4. Cerebral Palsy and ADL Sum 10+		10. Radiation treatments	
5. Fever with dehydration, pneumonia, or Vomiting, or weight loss or tube feeding			
6. A stage 3 or 4 pressure ulcer or 2 ulcers (any type) across all stages		If one of the above are checked, did we bill a SS RUG score?	

STOP if answer is YES, Proceed if answer is NO

Resident Name ________________________**Resident #** ______ **Month Being Reviewed** ___________

MDS Quick Audit **Continued**

By reviewing the Medical Record and supportive documentation, answer the following questions.

CLINICALLY COMPLEX			
Within the applicable observation period, did the resident have:	Yes		Yes
1. Coma		10. Tube Feeding	
2. Dehydration		11. Transfusions	
3. Pneumonia		12. Dialysis	
4. Internal Bleeding		13. Oxygen Therapy	
5. Septicemia		14. Chemotherapy	
6. Burns		15 Multiple physician order changes or visits.	
7. Explicit terminal prognosis (Not in Version 5.12)			
8. Hemiplegia and ADL Sum 10+			
9. Diabetes with daily injections			
If the above are checked, did we bill a CC RUG score?			
STOP if answer is YES, Proceed if answer is NO			
IF THE RESIDENT'S RUG SCORE FALLS BELOW THE CLINICALLY COMPLEX LEVEL, DID WE BILL A RUG SCORE THAT STARTS WITH I,B OR P?			Yes

Resident Name ________________________**Resident #** ______ **Month Being Reviewed** ____________

Data Entry and Forms Review

Expedited Review (Notice of Medicare Provider Non-Coverage) Notice

	YES	NO	Comments
1 Has Medicare been discontinued during the month being reviewed? If no, skip questions 2-6.			
2 *If Yes, Is the Expedited Review Notice form present in the Resident's Financial File?*			
3 *Was the form issued at least 2 days prior to the last Medicare day?*			
4 *Is the form signed and dated 2 days before the last cover day by the resident or financial power of attorney?* If yes skip questions 5-7			
5 *If no, is the additional information section (telephone notice) completed?*			
6 *If yes, a certified mail or certificate of mailing receipt is located in the resident's financial folder?*			
7. *If the form is not signed and the notice was not given by phone, was the form sent Federal Express with the receipt in the financial folder?*			

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Part A Consolidated Billing Log

	YES	NO	Comments
1 Is the log completed and signed by nursing and given to the ED weekly?			
2 Has the ED reviewed the log and forward to the Business Office weekly?			
3 Did the Business Office complete their portion of the Billing Log weekly?			

Therapy Logs

	PT	OT	ST	Comments for all NO answers
1 *Is there a CPT log present in the chart for the month being reviewed? (✓All that apply)*				
2 *If the resident has been discharged from all therapies is there a RST log present on the chart?*				

Resident Name ________________________**Resident #** ______ **Month Being Reviewed** ___________

In House Review ACTION PLAN

Following the completion of all components, the review team will develop an action plan for any exceptions noted in the review.

Issue Identified	**Corrective Action**	**Responsible Person(s)**	**Due Date**	**Date Resolved**

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Signature of Associates

Name of Associate	Signature	Section(s) Reviewed	Date Reviewed

Resident Name ________________________Resident # ______ Month Being Reviewed ____________