

ATTACHMENT B



HANSEN HUNTER & CO. P.C.

Certified Public Accountants

Firm Information
Clinical Services

800.547.3159

TABLE OF CONTENTS

Section 1- Contract Corporate Compliance
& Ethics Program Support

Section 2- Audit Process

Section 3- Clinical Education Examples

Section 4- Value Added Services

**CONTRACT CORPORATE
COMPLIANCE & ETHICS
PROGRAM SUPPORT**

CONTRACT CORPORATE COMPLIANCE & ETHICS PROGRAM SUPPORT

The following is a typical support package of services:

1. **Compliance & reimbursement audits** of the highest level. We spend an average of 3 hours per chart (these are not checklist audits) with both an RN, CPC and a therapist who review MDS accuracy and nursing/therapy documentation to ensure the Medicare/Medicaid claims are supported and proper reimbursement was realized. The staff is interviewed, systems are reviewed and a formal exit conference is held.
2. **Intensive clinical/administrative education** by Carol Maher who is on the board of AANAC and a consultant to CMS for the development of MDS 3.0 and RUG-IV. Sample offerings (not exhaustive):
 - a) *MDS Intensive 3.0* (see example below) with CEUs/ NAB credits
 - b) *Successfully Managing Medicare Processes for Administrators* (see example below) with NAB credits
 - c) *ADLs; PPS Scheduling; Medicare Documentation; Section M; Quality Measures*
3. **Intensive therapy documentation education** by Jodie Bittinger, M.A., CCC-A/S.L.P., and/or Alicia Moore, M.S.O.T., of HHC. This is an intensive 1½-day therapy-oriented Medicare documentation class (see example below). These therapist consultants also provide 1:1 rehab manager mentoring/training, as needed.
4. **Monthly webinars** see below for a few past topics:
 - a) *Change of Therapy OMRAs* with CEU/ NAB credits
 - b) *Medicare Beneficiary Notes* with CEU/ NAB credits
 - c) *New CMS Guidance on ADLs* with CEU/ NAB credits
 - d) *Quality Measures* with CEU/ NAB credits
 - e) *The MDS Correction Process* with CEU credits
 - f) *Successfully Managing The Medicare Review Process: ADRs, RAC Audits, Certs, ZPICS, OIG, QIO Requests for Documentation* with CEU
 - g) *RAI Manual Updates, RUG-IV Transition and PEPPER Reports* with CEU
 - h) *Basic Medicare Coverage: How Has The Jimmo v. Sebelius Settlement Affected Medicare Coverage?* with CEU/ NAB Credits
5. **Education of staff and personnel** based on findings (after consultation with corporate management).
6. **Phone support** to clinical and corporate personnel to answer questions as they occur.

AUDIT PROCESS

- Chart audits for determining MDS assessment accuracy with review of the supporting nursing, therapy, and other documentation to evaluate whether the claims are supported and whether proper reimbursement was realized. This involves:
 1. Using a report from the facility's MDS software (a type of PPS assessment history report) to guide sample selection;
 2. Review of the medical record documentation by the nurse reviewer and therapist reviewer;
 3. Review of the MDS assessments to evaluate for:
 - Timely opening of assessments [if late, what is/are the system issue(s), or root cause, contributing to the problem].
 - Timely completion of assessments [if late, what is/are the system issue(s), or root cause, contributing to the problem].
 - Accuracy of MDS reasons for assessment [if in error, what is the underlying problem...system issue or knowledge deficit?].
 - Accuracy of MDS assessment coding compared to the medical record documentation [if errors, are they isolated or widespread, and do those errors relate to assessment methodology (the MDS nurse does not assess the patient or interview caregiver staff, or, does not review the medical record documentation); knowledge deficits (the MDS nurse does not refer to the RAI Manual for coding clarification/guidance, or, applies only one coding principle to every item on the MDS); or, potential system issues [i.e., a mentoring nurse provides his/her own inaccurate interpretations of the RAI process to the current MDS nurse assessor who then applies that erroneous process to the assessments, or, the facility uses an RAI process model that parcels out the MDS assessment across all nursing staff across all shifts].
 - Specific focus on documentation to support the late-loss ADL coding (contributing to all RUG outcomes), therapy coding (contributing to rehab RUG outcomes), and the qualifying elements contributing to the non-rehab RUG outcome.
 - Nursing documentation review to determine sufficiency to support skilled need. Are there underlying system issues to consider (i.e., nurses required to document the same information in multiple locations in the record creating inefficiencies and/or contradictory information)? Are nurses "cloning" their documentation (i.e., cut and paste by one nurse from one day to the next, or by multiple nurses across multiple days – complete with copied documentation errors) raising the question of whether services were even provided on days subsequent to the original note?

- Review of all available therapy documentation to determine reasonable and necessary status for the case. Review of the documentation moves beyond a checklist of whether or not a document exists in the record; the review looks at whether the documentation had made the case for (or justified) the services provided and billed. If documentation does not exist, reviewers assess for system issues that would be contributing to the lack of documentation. If therapy modes and/or modalities lack accurate application of billing rules, reviewers explore for underlying system issues or knowledge deficits (i.e., has the therapy vendor not provided sufficient education to their therapy staff to understand accurate mode and modality billing?; are electronic timing devices being utilized improperly which have resulted in misreporting of therapy minutes; are therapists billing for treatment time via use of the device when not actually in the facility?). Also, is there any indication that the therapy vendor focuses on provision of “ultra high” level of rehab without consideration of the patient’s medical instability?
 - Focused review of keys areas that can be costly errors if out of compliance: Change of Therapy review process; COT OMRA completion; End of Therapy OMRAs; missed opportunities for appropriate continuation of the Medicare Part A stay by non-use of the EOT OMRA for continued coverage for skilled nursing services.
- Interview of key staff (i.e., MDS nurse, therapy staff, billing staff) as an additional evaluative tool to determine their knowledge level of MDS/PPS, as well as assessment process, documentation practices/processes, and billing process.
 - On-site observation of therapy services during the audit process to determine accuracy of billing of therapy modes of service, modalities, and time submitted to the MDS, as well as to ensure that therapy vendor practices do not create areas of risk for the SNF provider. On-site observation all considers appropriateness of the time of day when services are provided (i.e., is physical therapy gait training really appropriate for the patient at 5:30 a.m.); environment of the rehab gym (i.e., is a television on throughout the day creating notable distraction to the patients and therapists?); schedule of the therapy day (i.e., were all 30 patients on caseload treated in the rehab gym between 8:00-noon with no therapy service provided in the afternoon with therapists “hanging out” all afternoon?).
 - Review of other relevant systems that correlate to the claim (i.e., physician certs/re-certs; physician orders; denial and beneficiary notices; MDS assessment transmissions).
 - Review of the UB-04 claim for accuracy of (1) flow of the HIPPS codes and billable days per HIPPS codes to the claim (i.e., is the software pulling the information accurately – several software programs have had errors in this regard since the inception of MDS 3.0); and, (2) is the claim supported based on the review of the record?

Additionally:

- On-site education is provided, as needed, for identified areas of concern.
- In-depth report of audit findings with Executive Summary; Findings and Recommendations narrative analysis to include sample references, rationale for concern, regulatory references to support the finding, and recommendations for the facility (as well as company-wide recommendations, if pertinent); Chart Observations detail that may be used, if desired, as a follow-up tool for specific staff; and Confidential Sample List. A separate “Therapy Only” version of the report may be created in therapy vendor situations as a tool for vendor follow-up without providing the entire report detail to the vendor.

HHC clinicians have identified many areas of concern over their years of auditing. Some of these concerns have been longstanding problems within a facility. Other times, the identification of a knowledge deficit or a coding methodology enables the reviewer to provide immediate regulatory feedback and correction to avoid perpetuation of the problem over a period of months or years (either from a reimbursement, survey, or quality standpoint).

HHC is also able to provide education in the areas of MDS/PPS, nursing and ADL documentation, Quality Measures, therapy documentation compliance training, rehab manager mentoring, and ICD-9 coding (current system) and ICD-10 coding (implementation October 1, 2015).

ATTACHMENT C

CLINICAL EDUCATION EXAMPLES

MDS 3.0 Intensive Objectives (Day 1)

1. List the OBRA required assessments.
2. Define the timing requirements for each OBRA assessment.
3. Describe the three types of discharge assessments/tracking forms.
4. Understand the importance of “setting the ARD” for OBRA and PPS assessments.
5. Report the documentation requirements of resident/staff interviews.
6. List the four (4) late-loss ADLs.
7. Describe the differences between independence, supervision, limited assistance, extensive assistance and total dependence.
8. Understand how to complete a balance test for MDS purposes.
9. Describe a “toileting program” that qualifies for MDS coding.
10. Describe how to determine whether a diagnosis is “active.”
11. List the four (4) requirements that must be present before coding an active diagnosis of urinary tract infection on the MDS.

MDS 3.0 Intensive Agenda (Day 1)

9:00 - 9:15 am	Welcome, introductions, orientation to facility, course objectives, review of syllabus and/or handouts
9:15 - 10:30 am	OBRA assessments, basic MDS regulations, terms, timelines. (These items are “must learns” for MDS Coordinators.) Each MDS type has its own unique timelines and completion requirements.
10:30 - 10:45 am	Break
10:45 - 11:15 am	Section A coding. Important information covered in this section includes demographics, PASSR, Reasons for Assessment, Medicare Start and End dates (critical for Medicare coverage and payment) and Entry tracking forms.
11:15 - 12:30 pm	Resident and Staff interviews (timelines, instructions and use). Section B&C: Hearing, vision, cognition; add Social Worker for interview process.
12:30 - 1:00 pm	Lunch
1:00 - 2:00 pm	Sections D & E. Mood and Behavior (Social Service added here). These sections will include a video example of the correct way to conduct an interview plus coding instructions for each of the behavior items. Care Planning will be discussed.
2:00 - 2:30 pm	Section F: Activities. A short video of an Activity Interview will be played, followed by group discussion of how to use the information from the “preferences” interview to provide individualized care for the residents.
2:30 - 2:45 pm	Break
2:45 - 4:30 pm	Section G: ADLs, add Therapy Director, DSD. This section of the day includes the “must learn” items for MDS coding and reimbursement. The instruction includes didactic information, a demonstration of the ADLs using bed, chair, gown, tray, etc. There are practical coding exercises from medical record copies completed during this time, as well.
4:30 - 5:00 pm	Section H: Continence. This section of the MDS includes Quality Measure items of continence and indwelling catheter use. The specifics of a bowel or bladder toileting plan will be discussed along with MDS coding instructions.
5:00 - 5:30 pm	Section I: Diagnoses. The CMS requirements for coding of “active diagnoses” will be carefully reviewed. The specific coding instructions for urinary tract infections and quadriplegia will be discussed. Medicare payment and Quality Measures depend upon the accuracy of these MDS items.
5:30 - 6:00 pm	Quiz
6:00 pm	Dismissal

MDS 3.0 Intensive Objectives (Day 2)

1. Define a “fall” for MDS purposes.
2. Verbalize when the pain interview must be completed.
3. Describe how to determine significant weight loss and weight gain.
4. Explain how to determine whether a pressure ulcer is “present on admission.”
5. Describe the pressure ulcer stages and qualifications for each stage.
6. Define what the qualifications are for “worsening in pressure ulcer status.”
7. Define “physical restraint.”
8. State 3 examples of significant change in condition criteria for decline.
9. List 3 examples of significant change in condition criteria for improvement.
10. Explain the requirements for Care Area Assessment completion.

MDS 3.0 Intensive Agenda (Day 2)

9:00 - 9:15 am	Welcome, introductions, orientation to facility, course objectives, review of the Day 1 quiz. Frequently missed questions from the Day 1 quiz will be reviewed. ADL coding will also be reviewed. Questions will be answered.
9:15 - 10:30 am	Section J: This important clinical section includes coding instructions for pain (long and short stay Quality Measures), pain interview and pain scales, fever, shortness of breath (RUG payment item), prognosis, and falls. This section will conclude with a practical coding exercise to ensure the fall instructions were understood.
10:30 - 10:45 am	Break
10:45 - 11:30 am	Section K: Nutrition. The Dietitian should be included in the discussion of this section, if possible. The nutrition section provides the nursing team with the opportunity to observe the resident’s ability to eat with new eyes. The items include assessing the resident’s ability to swallow, weight and height, along with how to correctly calculate significant weight losses and weight gains, identifying IV fluids provided for nutrition or hydration, tube feeding and therapeutic diets.
11:30 - 12:00 pm	Section L: Oral dental care. The assessment of the resident’s mouth will be taught along with the focus on identifying ulcers, infections, broken or decayed teeth and broken or ill-fitting dentures. Poor oral care can lead to infections and unstable blood sugars.
12:00 - 12:30 pm	Section N: Medications. This section includes medications that affect Quality Measures (antipsychotics, hypnotics, anti-anxieties (anxiolytics), and antidepressants), as well as anticoagulants, antibiotics and diuretics. The CMS coding instructions for each of the medication items will be carefully reviewed.
12:30 - 1:00 pm	Lunch
1:00 - 3:00 pm	Section M: Skin care. This very important MDS section focuses on the identification of pressure ulcers (risk, staging, presence on admission, worsening, healing), other skin ulcers, and skin ulcer care. The items in this section are all RUG reimbursement items and many of the items also affect Quality Measures. This section ends with a practical exercise in coding skin items from a sample medical record to reinforce learning.
3:00 - 3:15 pm	Break
3:15 - 4:15 pm	Section O: Special treatments, procedures and programs. This section contains many RUG payment items that require knowledge of the coding instructions. Of special concern are the 3 extensive nursing services: tracheostomy care, ventilator/respirator use, and strict isolation. The vaccine items (PPV and influenza) are also discussed. The specific requirements and benefits of restorative nursing service are also covered.
4:15 - 4:30 pm	Section P: Restraints. The restraint items trigger Quality Measures and are publically reported. The assessor must understand the difference between the intent of the device and the “effect” of the device. Restraints are coded when the device has the “effect” of restraining the resident regardless of the intent of the device.
4:30 - 4:45 pm	Section Q: Discharge Potential. Discharge planning is a priority in nursing home care. All residents, not just short-stay residents, must be offered the opportunity to discuss the possibility of discharge. Section Q opens this discussion to all residents regardless of payer, diagnoses or functional abilities.
4:45 - 5:15 pm	Significant Change in Status. The requirements for Significant Change, including decline or improvement, are reviewed. Best practices for documentation of the clinical determination of significant change will also be discussed.
5:15 - 5:45 pm	Care Area Assessments. The requirements for CAAs will be reviewed. Sample CAAs will be shared with the attendees along with best practice suggestions.
5:45 - 6:15 pm	Quiz
6:15 pm	Dismissal

MDS 3.0 Intensive Objectives (Day 3)

1. Describe the components of the SNF PPS daily rate.
2. List the major RUG categories.
3. Understand the importance of optimal PPS ARD scheduling.
4. Explain when default rate is charged.
5. Report how MDS corrections affect PPS billing.
6. Explain the “midnight rule’s” effect on billing.
7. List three (3) examples of direct skilled nursing services.
8. Explain the timing of Medicare Physician certifications/re-certification signatures and dates.
9. State which dates are allowable to set the ARD for an End of Therapy OMRA.
10. Describe the rolling Change of Therapy OMRA windows.
11. List three meetings that are often used to manage the Medicare PPS process.

MDS 3.0 Intensive Agenda (Day 3)

9:00 - 9:15 am	Welcome, introductions, orientation to facility, course objectives, review of the Day 2 quiz. Frequently missed questions from the Day 2 quiz will be reviewed. ADL coding will also be reviewed. Questions will be answered.
9:15 - 10:00 am	Section O: Correct coding of therapy days and minutes. CMS has updated the instructions for coding therapy. These changes affect Medicare payment. It is critical that the MDS nurse understand how to correctly code these important payment items.
10:00 - 10:45 am	RUGs. The qualifications for each of the 66 Medicare RUGs will be reviewed. It is important for the Medicare team to understand which MDS items trigger the RUGs and how that affects the Change of Therapy OMRA and Start of Therapy OMRA decisions. ADLs are critical components of each RUG. This session will discuss how the ADL score is obtained from the MDS coding of the 4 late-loss ADLs.
10:45 - 11:00 am	Break
11:00 - 12:30 pm	Medicare Clinical Coverage. This session will discuss the basic requirements for Medicare coverage: 3-day qualifying stay, daily skilled services, and the Medicare benefit period. The daily skilled services will each be discussed to ensure the licensed nurses understand not only what daily skilled services are, but the important documentation components required, as well. Medicare Certifications and Re-certification regulations will be reviewed. The nursing team usually either completes these important documents before the physician signs or oversees this critical process.
12:30 - 1:00 pm	Lunch
1:00 - 2:30 pm	Medicare Beneficiary Notices. There are seven (7) Medicare Beneficiary notices that must be presented to Medicare beneficiaries when services end. Each notice has specific regulations and timelines. This presentation helps the nurse make sense of the process by walking through the Medicare stays and discussing when and why each of those notices are necessary.
2:30 - 2:45 pm	Break
2:45 - 4:45 pm	Scheduling PPS Assessments. The PPS assessment scheduling is extremely complex. There are complicated requirements that continue to be changed/clarified/updated by CMS. The presentation begins with the basic requirements for the scheduled PPS assessments. The presentation then helps walk the attendees through the OMRA’s (Other Medicare Required Assessments). A late or missed OMRA can have significant financial implications to the Skilled Nursing Facility. The nurses and therapists must work closely together to set Assessment Reference Dates for the scheduled and unscheduled assessments and to track the rolling 7-day windows for Change of Therapy (COT) OMRA’s. Because of the new regulations for COTs, Medicare residents are in an MDS look-back window nearly their entire Medicare stay. A Change of Therapy OMRA observation tool will be shared. End of Therapy OMRA and End of Therapy OMRA with Resumption regulations are presented. Another PPS assessment that often is not completed correctly is the Medicare Short Stay Assessment. Because of the new RUG requirement for 5 distinct calendar days of therapy for Rehab RUGs, the Short Stay Assessment is often required when residents are in the Medicare stay less than 5 calendar days. There are eight (8) requirements that must be met before a Short Stay Assessment can be completed. Those requirements will be reviewed and a reusable tool will be distributed to help the facility teams to keep track of those 8 requirements. The presentation ends by sharing some best practices for managing the process. The usual meetings that facilities use to manage the PPS processes are daily PPS Utilization meetings, weekly Medicare meetings and monthly Triple Check meetings. Tools and best practice suggestions for each of these meetings will be discussed.
4:45 – 5:30 pm	Final Exam
5:30 pm	Dismissal

Successfully Managing Medicare Processes for Administrators Learning Objectives

1. Describe the components of the SNF PPS daily rate.
2. List the major RUG categories.
3. Verbalize the importance of optimal PPS ARD scheduling.
4. Explain when default rate is charged.
5. Report how MDS corrections affect PPS billing.
6. Explain the effect of the “midnight rule” on billing.
7. List three (3) examples of direct skilled nursing services.
8. Explain the timing of Medicare Physician certifications/re-certification signatures and dates.
9. State which dates are allowable to set the ARD for an End of Therapy OMRA.
10. Describe the rolling Change of Therapy OMRA windows.
11. List three meetings that are often used to manage the Medicare PPS process.
12. State the main purpose for the Daily PPS Meeting.
13. State the main purpose for the weekly Medicare meeting.
14. State the main purpose of the monthly Triple Check meeting.

Successfully Managing Medicare Processes for Administrators (Day 1)

MDS Basics for Administrators-What is an MDS, why is it required, what are the uses of the MDS, how is the MDS accuracy measured? The MDS is the only assessment that is required to be completed in every skilled nursing home company in the nation. The MDS is used as a basis for Medicare payment (SNF PPS) and for Medicaid reimbursement in Case Mix States. Additionally, the MDS is basis for the SNF Quality Measures that are nationally reported on the Nursing Home Compare website. A number of those Quality Measures are used in the calculation of the facility’s 5-star rating, as well. Pre-survey and survey activities are also based upon the MDS resident responses. (10.01, 10.02, 50.13)

Activities of Daily Living- The basics, how the ADLs affect payment, how to oversee the accuracy. The Office of Inspector General and the PEPPER report have identified Activities of Daily Living (ADLs) as placing the facility at high risk for billing irregularities. The ADL portion of the RUG score has as much impact as the therapy days and minutes. The accuracy of the ADL coding will be stressed. The nursing ADL documentation should support the need for therapy services. The Administrator must understand the ADL scoring and encourage the staff, including direct care staff, to carefully document each ADL episode. The ADL scores impact Medicare reimbursement, state Case Mix reimbursement, and are important factors in RAC Medicaid reviews, as well. It is important to understand the residents’ ADL status when discharges are planned to help ensure safe discharge plans are in place. (10.02, 50.13)

Medicare Basic Clinical Coverage- The 3-day qualifying stay, benefit period, daily skilled services, delayed coverage, consolidated billing. This presentation carefully covers critical requirements for Medicare coverage including: 3-day qualifying stay vs. observational stays; Medicare certifications/re-certification forms; Medicare benefit period; clinical coverage requirements; consolidated billing; Midnight Rule; Medicare coverage in special situations, such as hospice and behavior monitoring; provider notifications of Medicare coverage with examples of covered and non-covered situations from the Medicare Manuals. (10.02, 10.10, 10.14, 50.13)

Medicare Certifications and Re-Certifications- This critical process is one of the gold-standard requirements for Medicare coverage. The administrator must ensure that the Medicare Certification system is solidly in place. In addition to a solid system, the administrator must ensure that there are no system breakdowns with staff turnover in the medical record position, Medicare manager position or medical director position. The administrator must understand the requisite timeframes for each of the Medicare certifications/re-certifications and how to manage the systems when there is an occasional system breakdown. (10.08, 50.01, 50.13)

Medicare Beneficiary Notices- This process is critical to facility payment. When a resident is not provided with a required Medicare Beneficiary /Denial Notice, no other payer may be billed. The Administrator must be fluent in the critical process. Each type of Medicare Notice is carefully reviewed along with the requirements for each notice and the pitfalls of incorrectly presenting or preparing each notice. (10.08, 50.01, 50.13)

Successfully Managing Medicare Processes for Administrators (Day 2)

Therapy days and minutes- What therapy can be counted, refusals, and oversights. Therapy days and minutes must be correctly documented and coded on the MDS in order to receive the correct Rehab RUG for Medicare and Medicaid Case Mix. Administrators must ensure that their therapists fully understand the MDS requirements for documentation and requirements for RUG groups. Often, therapists become dependent upon their software and are not aware of all of the requirements for Rehab RUG groups. This can lead to Medicare payment that is less than anticipated. There have been recent additions to the RUG payment system affecting the RUG calculations. The Administrators must ensure that their therapists/therapy vendor is aware of the new changes and is considering the new requirements when providing therapy services. (10.10, 10.14, 50.13)

RUG-IV- Qualifiers for each RUG group, presumption of Medicare coverage, ensuring that the team understands the RUGs for COTs and presumption. This presentation will help the Administrators to understand Medicare Administrative Presumption of Coverage. The Administrator will also need to understand the qualifiers for each of the Medicare RUGs including ADL scoring. The entire facility Medicare team must understand the RUG system in order to make correct decisions for scheduling PPS assessments. (10.14, 50.13)

Successfully Managing PPS Assessments- Understanding the complex regulations, basics of setting ARDs, COTs, SOTs, and census events, Midnight Rule, hospital admission, and observational stay of >24 hours. This presentation is the culmination of the 3-day Intensive MDS class. Medicare payment is dependent upon the MDS completion and coding. Without MDS assessments completed in a timely manner, Medicare payment will not be allowed. This course teaches the critical impact of setting Assessment Reference Dates (ARDs) for both scheduled and unscheduled PPS assessments. The rules for the scheduled (5-, 14-, 30-, 60- and 90-day) PPS assessments will be instructed. The unscheduled (Other Medicare Required Assessments (OMRAs) and Significant Change in Condition Assessments), including the Change in Therapy OMRA and the End of Therapy OMRA with and without resumption will be covered. The Administrator must ensure that his/her team completely understands the rules for setting the ARDs for each of these important assessments. The facility PEPPER report can assist the Administrator to determine whether the facility is seen to be at risk for improper billing with higher or lower percentiles of PPS assessments in the Ultra High category, higher or lower than expected ADL scores for either Rehab RUGs or nursing RUGs, and the Change of Therapy OMRAs as compared to the national averages. How to manage the census events that impact the PPS schedule by a daily PPS meeting will be reviewed. The importance of both a weekly Medicare Meeting and a monthly Triple Check Meeting will also be discussed. The Administrator should ensure that these important processes are in place and being effectively completed. (10.10, 10.14, 50.01, 50.13)

Daily Utilization (PPS) Meeting-- The purpose of this daily meeting is to carefully review each Medicare resident's MDS PPS schedule. The Assessment Reference Dates must be set in a timely manner in order to capture the care and services provided in the facility and to obtain the optimal RUG score. With the advent of the Change of Therapy (COT) OMRAs, each Medicare resident is always in a potential assessment window. The administrator must ensure that his staff members understand the complex MDS PPS assessment schedules and are carefully and consistently setting Assessment Reference Dates and opening the assessments in the facility software in a timely manner. The presentation will include role-playing and live examples of effective vs. ineffective meetings. (10.10, 10.14, 20.01, 50.01, 50.13)

Weekly Medicare Meeting- The purpose of this weekly meeting is to carefully review each Medicare resident's clinical coverage. The team reviews the weekly documentation, the resident's clinical progress, progress with therapy, and discharge plans/barriers to discharge. This is also a time to review the Medicare certifications/re-certifications and the MDS accuracy and schedule. Medicare coverage decisions are made at this meeting and goals are set. The facility administrator ensures that the meeting is being consistently completed and that valuable information is reviewed to safeguard the facility's Medicare PPS process. Live demonstrations of an effective meeting will be presented. (10.10, 10.14, 20.01, 50.01, 50.13)

Monthly Triple Check Meeting- The purpose of this meeting is to ensure that the facility's UB-04s are accurate prior to monthly Medicare billing. The medical records are reviewed to verify resident identification information, therapy days and minutes, nursing coverage, lab, x-ray and medications billed. The administrator must ensure that the facility's billing processes are clean and efficient. The PEPPER report revealed that one out of four Medicare claims were billed incorrectly. The Administrator must hold staff accountable for this critical process. The presentation will include a live demonstration of an effective meeting process. (20.01, 30.03, 30.05, 30.07, 50.01, 50.05, 50.13)

PEPPER Reports- The PEPPER reports are only distributed to facility administrators. The reports alert the administrators about potential billing issues and how their facility's billing compares to other skilled nursing facilities. All Nursing Home Administrators need to understand what this report measures and how to use the information to ensure that their billing practices are solid. As part of a compliance program, a SNF should conduct regular audits to ensure services provided are necessary and that charges for Medicare services are correctly documented and billed. The PEPPER can help guide the SNF's auditing and monitoring activities. Domains of practice: (10.14, 30.05, 30.06, 30.07, 50.05, and 50.13)

Rehabilitation Compliance Training Objectives:

1. Define rehabilitation compliance and the role of compliance in the skilled rehabilitation environment.
2. Recognize and understand the roles that ZPICs, RACs, and OIG play in rehabilitation in the skilled nursing environment.
3. Explain the Federal False Claims Act in regard to rehabilitation in the skilled nursing environment.
4. Be able to apply Medicare Benefit Policy, Chapters 8 and 15; and the RAI Manual Chapter 3, Section O and Chapter 6 into daily rehabilitation management.
5. Define modes of therapy and describe appropriate scenarios for their use in the skilled nursing environment.
6. List the requirements for achieving each of the five (5) RUG levels including both minutes and days needed, as well as any additional qualifiers.

Rehabilitation Compliance Training Day 1	
10:00 - 10:30 am	Introduction and Welcome
10:30 - 11:00 am	Rehabilitation Compliance – What does it mean for you and what’s all the fuss about?
10:30 - 10:45 am	Break
11:00 - 11:30 am	Documentation Resources for Medicare Compliance Medicare Benefit Manual Chapter 8 Medicare Benefit Manual Chapter 15
11:15 - 12:30 pm	Resident and staff interviews (timelines, instructions and use). Section B&C: Hearing, vision, cognition; add Social Worker for interview process.
11:30 - 11:40 am	Break
11:40 - 1:00 pm	Documentation Resources for Medicare Compliance (continued) RAI Manual RUG-IV Knowledge and The Role of the Rehabilitation Director in Interdisciplinary Meetings
1:00 - 2:00 pm	Lunch Break
2:00 – 4:00 pm	Pitfalls in Documentation – The documentation concerns seen in auditing and how to prevent them from occurring in your facility
4:00 – 4:15 pm	Break
4:15 – 7:00 pm	Clinical Documentation Guidelines
Rehabilitation Compliance Training Day 2	
8:00 - 9:00 am	Breakfast Review and Clinical Documentation Guidelines
9:00 - 10:30 am	Clinical Documentation Guidelines
10:30 - 10:45 am	Break
10:45 - 12:30 am	How Do You Audit? Complete Therapy Documentation Audits Large and small group clinical analysis and auditing
12:30 - 1:30 pm	Therapy Functional Reporting and Part B
1:30 - 2:00 pm	Conclusion, wrap-up, questions

Mock Survey Objectives

1. Improve state survey results.
2. Ensure that current “hot” survey issues are addressed.
3. Identify best practices or problem solutions to help minimize potential survey risk.
4. Collaborate with facility staff in each department to identify all areas that might affect state survey results.
5. Provide a detailed outline and examples of items needed in order to be prepared at any time for your state survey. This includes having an accurate and complete “survey readiness notebook.”
6. Improve staff knowledge and communication:
 - o Provide a realistic state survey experience that allows your staff the opportunity to practice under real-life conditions.
 - o Assist staff with learning how to communicate during stressful situations to best support the survey process.
 - o Ensure staff understands the key areas state and federal survey personnel will investigate and how to best support these areas to avoid unnecessary citations and deficiencies.
 - o Ensure facility staff understands the results of the mock survey including current deficiency findings and plan of action.
7. Ensure that the facility policies and procedures have the most current federal regulation language to support facility compliance.
8. Immediate notification of deficient or non-compliant practices within the facility and identification of whether they are isolated, patterned, or widespread issues.

Mock Survey On-site Tasks/Agenda

Arrive at an unknown time to facility.

Conduct a thorough, unannounced survey including initial walk-through.

Perform an initial entrance conference.

On-site observation of:

- o **Treatments and Medications**
- o **Wound treatment and management**
- o **Medication pass**
- o **Facility environment**
- o **Patient care**
- o **Infection control practices**
- o **Food preparation, service and delivery**

Review of current policies and procedures and ensure current regulatory criteria are included.

Review of medical staff files, medical credentialing, and staff personnel files.

Review and investigate health information systems to ensure regulatory compliance

Complete medical record reviews utilizing the tracer system from admission through discharge of both closed and active records.

Evaluate and assess the last six months of reportable investigations.

Evaluate and assess the last six months of incident reports.

Evaluate and assess accuracy of MDS completion.

Assess and identify infection control measures and infection control patterns in the facility.

Investigate and assess dementia care and treatment

Investigate and assess comprehensive and complete care plans.

Identify and review Quality Measures and assessments in your facility. Investigate a sample of those Quality Measures that have flagged as areas of concern. Provide input to improve quality assurance programs.

Review social services, activities, and dietary documentation.

Provide immediate on-site staff training to identify, address and improve deficient practices.

Tour the facility and determine potential physical plant violations and/or improvements.

Complete quality of life assessments. Interview residents to uncover further facility needs including conducting a resident council meeting.

On-site exit meeting with findings reported.

Completion of a follow-up formal mock survey report with identification of potential federal regulation deficiencies and recommendations.

Provide follow-up contact information for off-site questions, review and support. Upon facility request, return for follow-up investigation.

Assist with formal plans of correction completion following state and federal surveys, if needed.

VALUE ADDED SERVICES

VALUE ADDED SERVICES

ADR / RAC / ZPIC Management Services:

1. On-site training for Corporate staff regarding the proper process for ADR, RAC, ZPIC, etc. review and response
2. Webinar presentation that is archived and presented upon demand. This is updated as changes occur.
3. Assistance managing the process:
 - a. Reviewing audit requests,
 - b. Defining the necessary steps and timing needed
 - c. Assisting with who should be completing the tasks
 - d. Review sample claims documentation prior to submission for compliance
4. Provide a tool kit that would include:
 - a. Detailed checklists of documentation requirements for the facilities to prepare for the Medicare Review
 - b. Spreadsheet used to manage the Medicare reviews
 - c. Facesheet form required for Noridian reviews
 - d. Sample appeal letters
 - e. Medical record dividers to be used to organize the records sent
 - f. Appeal timeline document
 - g. CMS Program Integrity Manual related to Medicare Reviews
 - h. Signature attestation forms/signature log forms

Rehab Management Services:

1. Rehab Manager mentoring:
 - a. Guidance in the IDT approach
 - b. Time management
 - c. PPS understanding
 - d. Information on regulatory resources and practice management
2. Mentoring/guidance/education of individual therapists (which may include “shadowing,” as needed). This can address documentation and time management issues.
3. Education and guidance with regard to therapy staffing
4. Evaluation of departmental equipment use and needs
5. Analysis of therapy vendor contract from a perspective of helping the facility and suggesting contract language to mitigate potential problems following CMS regulatory changes.
6. Analysis of therapy vendor bills to the facility for accuracy of charges

MDS Nurse Assessor Services:

1. Mentoring/guidance/education of the MDS Nurse (which may include “shadowing,” as needed). This can address time management and documentation concerns/challenges.
2. Education and guidance with regard to PPS understanding.
3. Provide information on regulatory resources.
4. Education and guidance with regard to interview of C.N.A.s and licensed nurses.