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Angele Tran (tran@fsainfo.org, linkedin.com/in/angele-tran-96b9a666/) is Compliance Manager at Friends Services Alliance, Blue Bell, PA. She is a licensed occupational therapist in Pennsylvania.

Triple check process: An effective quality assurance tool for skilled nursing facilities

by Angele Tran, OTR/L, CHC, CAPS

In June 2023, the Centers for Medicare & Medicaid Services (CMS) launched a skilled nursing facility (SNF) 5-Claim Probe and Educate Review program. This program will impact every Medicare-billing SNF in the country. Medicare administrative contractors (MACs) will review a sample of claims from each SNF, address errors, provide education, and prevent future mistakes in documentation.

The change request submitted to the U.S. Department of Health and Human Services attempts to correct the improper payment rates, which were determined to be the top driver of the overall Medicare Fee-for-Service Improper Payment Rate. Based on the Comprehensive Error Rate Testing program for SNFs, there was a projected improper payment rate of 15.1% in 2022, up from 7.79% in 2021.[1]

The primary root cause of SNF errors was missing documentation. For example, some of the top reasons included missing nursing home records, physician's certification/recertification, signature logs to support a clear identity of an illegible signature, and plans of care by a physical, occupational, or speech therapist. Given this background, and the recent developments applied by CMS, providers should understand the importance of having an effective triple check process.[2]

The triple check process can mitigate billing with missing documentation and improper payments. This article aims to articulate why the triple check process is an effective tool to ensure compliance with Medicare regulations and prevent billing errors. In addition, it will outline who should be involved in the triple check, when an organization should complete the process, and some of the recommended steps for completing the process.

Background

In October 2019, Medicare changed the reimbursement model for SNFs to the Patient Driven Payment Model (PDPM). Medicare implemented this model to improve payments under the SNF Prospective Payment System (PPS). Although this shift has provided positive changes, it may also be a factor in the significant increase in improper payment rates.[3]

To alleviate the improper payment rates, CMS is implementing the 5-claim review strategy to accomplish maximum outreach and provide specific educational resources to all SNFs.

SNF providers will receive a letter from the MAC requesting to review a sample of five claims for prepayment review. The 5-claim reviews will be completed on a rolling basis, beginning with the top 20% of providers that show the highest risk based on MAC data analysis.

After the claim sample is complete, the contractor will send the individual provider a detailed result letter—even if there are no error findings. Depending on the error findings, individual claim payments may be adjusted, and MACs may reach out to schedule education, including widespread or one-on-one education. Providers with an error rate of 20% or less will be provided with widespread education, with an option for one-on-one education. Providers with an error rate of more than 20% will be offered one-on-one education in their results letter. MACs shall provide education that includes claim-specific information and allows the provider to ask questions and receive meaningful feedback.[4]