



TRIPLE CHECK PROCESS: AN EFFECTIVE QUALITY ASSURANCE TOOL FOR SKILLED NURSING FACILITIES

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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

Why should SNFs implement a triple check process?

The triple check process is among the most effective quality assurance tools for SNFs. The process aims to catch any potential errors or compliance issues before claims are submitted, reduce the risk of improper payments, and promote overall compliance with regulations – no matter the payment model. That said, the triple check completed under PDPM differs from the triple check that was completed under Resource Utilization Groups IV because the information that drives billing has changed.

The triple check process is a team effort that requires cooperation from individuals involved in care, such as the minimum data set (MDS) coordinator, biller, therapy manager, and social services. This interdisciplinary team reviews each claim and supporting document and provides an important check and balance to the billing process.

SNFs need to have a procedure to ensure that claims submitted to the government for Medicare and Medicaid services are accurate and complete. By implementing the triple check process, SNFs can comprehensively review Medicare Parts A and B claims to ensure compliance with Medicare regulations and prevent billing errors.

Although the triple check process is not required in any specific regulation, it is highlighted in various regulatory bodies and other professional associations as best practice and industry standards. An effective triple check process can help your organization avoid both sizable paybacks and the potential for future audits.

A triple check review process may include these steps:

- ◆ The biller notifies the triple check team when claims have been completed and are ready for review.
- ◆ The team determines a meeting date and time.
- ◆ Team members bring supporting documentation with them to the meeting.
- ◆ The team documents the appropriate triple check form and leads the review of each claim and item on the triple check form.
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- ◆ At the end of each meeting, all team members sign the triple check form to show evidence of attendance, attest to having provided accurate information, and know the action items for which they are responsible.
- ◆ Claims that were not identified as complete are not transmitted for payment.
- ◆ All team members report back to the biller on all action items in

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Figure 1



writing. All claims are held until they can be marked complete.

Specific elements that should be reviewed in a triple check process

In addition to the areas identified in Figure 1, another area a team can review during the triple check process is Notice of Medicare Non-Coverage (NOMNC) and Advance Beneficiary Notice (ABN) timeliness. The NOMNC allows the beneficiary to request an expedited determination from the Quality Improvement Organization. The ABN transfers the financial obligation to the beneficiary when Medicare is not likely to provide coverage when services are not medically necessary or custodial in nature.

NOMNC is required for beneficiaries receiving Parts A and B skilled services. For Part B, only beneficiaries living in a SNF facility require notification. It does not apply to assisted living/personal care beneficiaries, independent living, or an external community.

The timeline for the delivery of NOMNC is at least two calendar days before Medicare coverage ends or the second to the last day of service if care is not being provided daily. ABN should be issued far enough in advance to allow the beneficiary time to consider all available options related to potentially noncovered items or services.⁵

Who is involved in the triple check process?

The triple check process is a group effort that requires cooperation from a gamut of individuals involved in care, such as the MDS coordinator, finance/biller, therapy manager, and any applicable social worker or medical records representative. A compliance officer should also attend periodically to ensure that the triple check meetings regularly occur and according to the policy. The triple check team’s role is to review every claim and the supporting document that supports each claim. There must

be a team commitment to conduct triple checks monthly.

When should you do a triple check?

The triple check process is a monthly review and should be conducted once the MDS for the month has been completed and draft claims have been generated. The meeting should be well documented and carried out according to a predetermined checklist. Although an organization should complete a triple check monthly, special attention should be paid when there are clinical or financial software updates.

Reasons why SNFs hesitate to implement a triple check process

There are various reasons why SNFs may stall or avoid implementing a triple check process. A common reason is that it requires more time from an organization and its personnel. Implementing an

effective triple check process requires commitment from the entire team — not just one or two people.

Additionally, leadership must be committed to the process and periodically attend to ensure that it is happening as it should and that the team has the necessary support.

Another reason is that the triple check policy requires an organization to check 100% of its claims. Although tedious and more time-consuming, checking every claim reduces the chance of missing or insufficient documentation, which can lead to lost revenue in the long term.

An additional reason is that an automated system may pull information to claims. In today's digitized world, some organizations are entirely electronic and use data dumping to automate processes. However, it is not uncommon for errors to occur when exporting files from one system to another.

This happens commonly because of software updates, such as therapy software updates. Software updates may not happen frequently, but when they do, it increases the risk of mistakes. Without the triple check process, organizations will not have the opportunity to recognize or validate the risks that can occur in automated systems.

The benefit of a triple check process is that no one will submit a claim for payment until all elements of the triple check are verified. The potential for claims to be delayed and cash flow slowed encourages

team members to adhere to the process. Most importantly, they must attend each meeting, follow up on action items, and do their part to ensure accurate billing and supporting documentation.

In conclusion, implementing a triple check process benefits both CMS and SNFs. For SNFs, complying with Medicare regulations and preventing billing errors will save valuable time and money. For CMS, accurate billing and documentation are essential to ensure financial integrity, quality of care, and sustainability of Medicare programs. CT

Endnotes

1. Centers for Medicare & Medicaid Services, "Skilled Nursing Facility 5-Claim Probe and Educate Review," June 8, 2023, <https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/medical-review-and-education/skilled-nursing-facility-5-claim-probe-and-educate-review>.
2. Centers for Medicare & Medicaid Services, "2021 Medicare Fee-for-Service Supplemental Improper Payment Data," November 2021, <https://www.cms.gov/files/document/2021-medicare-fee-service-supplemental-improper-payment-data.pdf-0>.
3. Centers for Medicare & Medicaid Services, "Skilled Nursing Facility Probe and Educate Review," MLN Matters, Number: MM13164, June 5, 2023, <https://www.cms.gov/files/document/mm13164-skilled-nursing-facility-probe-and-educate-review.pdf>.
4. Dan Ciolek, "CMS Initiates National SNF 5-Claim Probe and Educate Review," AHCA NCAL, May 17, 2023. <https://www.ahcancal.org/News-and-Communications/Blog/Pages/CMS-Initiates-National-SNF-5-Claim-Probe-and-Educate-Review.aspx>.
5. Centers for Medicare & Medicaid Services, "Beneficiary Notices Initiative (BNI)," last modified April 4, 2023, <https://www.cms.gov/medicare/medicare-general-information/bni?redirect=%2Fbni%2F>.

Takeaways

- ◆ The Centers for Medicare & Medicaid Services 5-Claim Probe & Educate Review program will impact every Medicare-billing skilled nursing facility (SNF) in the country.
- ◆ The 5-claim process — which will be conducted on a rolling basis — results in the individual provider receiving a detailed result letter, and depending on the error rate, one-on-one education or widespread education will be offered.
- ◆ The triple check process is widely recognized as one of the most effective quality assurance tools for SNFs.
- ◆ The triple check process requires cooperation from various individuals in an organization, such as the minimum data set coordinator, biller, therapy manager, social services, and support from leadership and compliance officer.
- ◆ There are many reasons why an organization may hesitate to implement the triple check process. Still, it is an effective tool to reduce the chance of missing or insufficient documentation, resulting in lost revenue in the long term.