DPSQA
LIVING CHOICES-
ASSISTED LIVING FACILITIES

What is so important about documentation

Reimbursement vs recoupment

Over 1,000 claims flagged during “1” legislative audit

1). No documentation: PCSP, service logs, progress notes and supporting documentation isn’t either done or is done but isn’t submitted correctly.

2). Insufficient documentation:
missing dates, times, signatures, out of date PCSP, supporting documents showing that clients were in other facilities or unavailable due to (xyz)

3). Number of unit’s error:
units billed not being cross checked with units documented, miscalculation of units for type of service, billing for a full month when in fact client was an inpatient for part of the month

Total cost: $335,456 worth of questionable claims flagged in this "1" legislative audit which may still end in loss of revenue for the facilities involved.

DPSQA PROCESS MOVING FORWARD

5 % OF ALL ASSISTED LIVING FACILITIES WILL BE RANDOMLY SELECTED FOR REVIEW TWICE YEARLY.

3% OF THOSE 5% RANDOMLY SELECTED WILL BE ASKED TO SUBMIT BENEFICIARY CHARTS-THE OTHER 2% WILL RECEIVE ON-SITE REVIEWS.

THE GOLDEN RULE OF PROVIDING HEALTHCARE: IF IT ISN'T *DOCUMENTED* IT ISN'T DONE

***Golden Rule to the Golden Rule (for waiver clients): MAKE SURE THE SERVICES YOU PROVIDE ARE IN LINE WITH THE Person Centered Service Plan (PCSP) AND ARE THEN DOCUMENTED ACCORDINGLY. PCSP-plan of care (POC); care plan (CP), individual service plan (ISP), individual education plan (IEP).

FEDERAL GUIDELINES REQUIRE FACILITIES TO ENSURE THERE IS DOCUMENTATION TO SUPPORT:

1) **THE BENEFICIARY (CLIENT) IS ELIGIBLE**
2) **THE SERVICES OFFERED AND PROVIDED ARE IN ACCORDANCE WITH THE INDIVIDUALS PCSP**
3) **THE SERVICES ARE PROVIDED BEFORE BILLING IS SUBMITTED**

MEDICAID MANUAL: *LIVING CHOICES ASSISTED LIVING* ***<u>SECTION II</u>***

202.100 Records that Living Choices Assisted Living Facilities and Agencies Must Keep (subpart B)

"A provider must also maintain the following items in each Living Choices beneficiary's file…"

- The beneficiary's attending or primary care physician's name…
- …current plan of care (AAS-9503)
- Written instructions to the facility's attendant care staff
- Nursing/nursing services performed
- Dates/times…
- Progress notes
- Signature/initials
- …nursing evaluations
- Attendant care services…
- …monitor beneficiary satisfaction and quality of service

202.110 Attendant Care Service Documentation (subpart A)

"Documentation of attendant care services performed in accordance with resident's plan of care and a Registered Nurse's written instructions is required…"

Checklist can be implemented if the following guidelines are met: the PCSP is individualized, Remember each person must sign and date the service log with original signatures.

211.200 PLAN OF CARE (SUBPART B)

"…Living Choices services must be provided according to the beneficiary plan of care (PCSP). Providers may bill only for services in the amount and frequency that is authorized in the plan of care…may bill only after services are provided…"

(SUBPART C)

"…The assisted living provider employs or contracts with a Registered Nurse who implements and coordinates plans of care, supervises nursing and direct care staff and monitors beneficiary's status…

At least once every three months the assisted living provider RN must evaluate each Living Choices beneficiary…" THEN DOCUMENT IT

142.300 (subpart A)

"...The delivery of all goods and services billed to Medicaid must be documented in the beneficiary's medical record...Beneficiary records must support the levels of services billed to Medicaid Providers..."

Hardest hit areas were attended care services*:* ***REMEMBER*** that any billed services has to be approved and added to the PCSP. With any change of condition call the DHS/RN to have the PCSP updated.

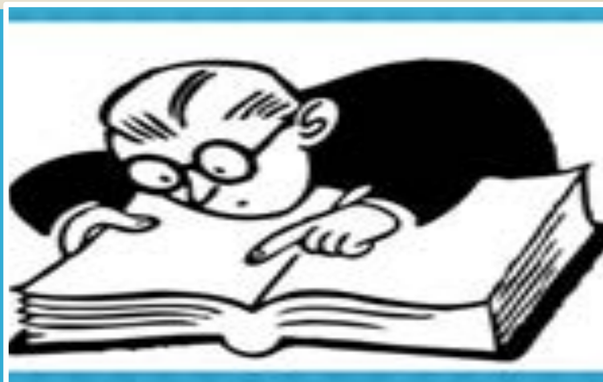
So keeping in mind that 'everything' requires over site;

MEDICAID MANUAL GENERAL POLICY SECTION I

142.300-Conditions Related to Record Keeping

(subpart D)

"...Upon request, each provider must furnish all original records in its possession regarding the furnishing or billing of Medicaid goods or services..."



USED BY STATE SURVEYORS WHO ENTER THE FACILITY TO CONDUCT PARTIAL AND/OR EXTENDED SURVEYS)

RULES and REGULATIONS for ASSISTED LIVING FACILITIES LEVEL II

SECTION 508: RESIDENT RECORDS

508.1-speaks to required physical documents
508.2 -speaks to maintenance of required documents

As we all know the primary intent of record review is to confirm or obtain needed information to make compliance decisions.

There are eleven areas that are usually flagged for review (no matter what type of audit)

HOWEVER THE FINDINGS IN ANY TYPE AUDIT USUALLY RESULTS IN MULTIPLE AREAS OF COMMON EVERYDAY SERVICES BEING DOCUMENTED INCORRECTLY OR NOT AT ALL;

SO WHAT NEEDS TO BE REVIEWED ON A CONSISTENT BASIS BY YOUR FACILITY?

THE FUTURE OF INDEPENDENT ASSESSMENTS

Current: the DHS RN makes a home visit to verify eligibility or continued eligibility for placement into an ALF.

An assessment is completed by the DHS RN to determine the care needs of the applicant.

The applicant is then allotted Living Choices waiver placement with Tier level based on the DHS RN's assessment.

There is potential for bias as the DHS RN is employed by the state who is contracted by CMS.

Future: Independent Assessors (IA) will make a home visit to verify eligibility or continued eligibility for placement into an ALF.

An assessment will be conducted by the IA to determine the care needs of the applicant.

The applicant is then allotted Living Choices waiver placement with Tier level based on the IA's assessment.

This will remove any potential bias as the IA will be separate and distinct from CMS and/or the state.

The DHS RN will continue to develop the applicants PCSP to reflect how best to ensure the individuals care needs will be met within the placement and Tier level determined by the Independent Assessors.

SO WHAT DOES THE ***PCSP*** IDENTIFY UNDER ***ATTENDANT CARE*** WITHIN THE ***BUNDLED WAIVER SERVICES?***

The care identified by the DHS/RN within the PCSP and the MINIMAL number of times that care is to be provided.

Daily/Weekly Minimums:

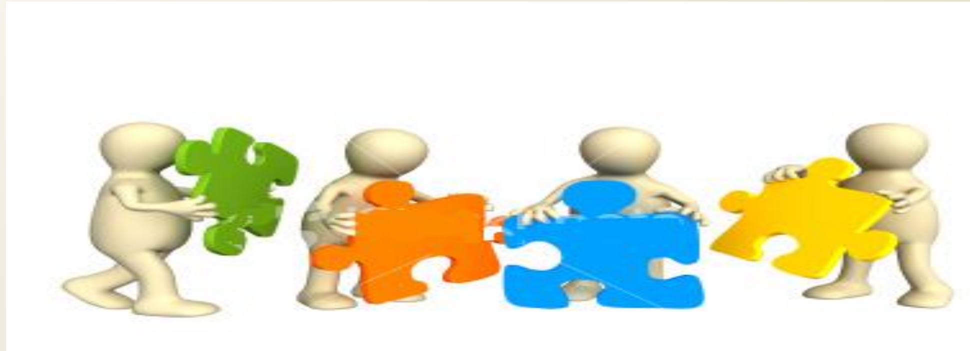
Have to be identified in the PCSP

Changes require PCSP update

PRN'S:
CHANGING NEEDS THAT REQUIRE UPDATED PCSP FOR BILLING

WHERE DO I FIND THE TIER LEVEL?

The Tier level is customized to the level of care of the beneficiaries needs and is documented on the Person Centered Service Plan (PCSP).



CAN THE TIER LEVEL CHANGE?

Yes, the Tier level can change if a reassessment verifies increases or decreases in beneficiary status.

BEST BILLING PRACTICES

Always pay attention when reassessments are done because the beneficiaries Tier level could have changed.

BEST BILLING PRACTICE REMINDER #1

Do not span date a claim for a month at a time because;

if the Tier changed during the month the whole claim for the month will be denied.

if you do accidently get paid at the incorrect tier the following will happen.

1. **You may be audited and the money of the incorrect tier will be recouped by OMIG and in some cases penalties may apply.**
2. **If it is not caught by your billing department you may end up losing money when the Tier level of a beneficiary increases but you continue to use the lower Tier level to bill. ***

BEST BILLING PRACTICE REMINDER #2

Always check your Remittance Advice (RA) to make sure you are paid correctly and to ensure your billing did go through with no errors.

WHAT ARE NON-WAIVER SERVICES AND HOW DO THEY IMPACT ARCHOICES BENEFICIARIES?

(non-billable; however, facility is still required to assist client in meeting these needs if applicable)

Remember: whether waiver driven or not, complete and accurate documentation is essential for bottom-line billing and payment.

Increased Revenue equals

1) Happier Boss
2) Happier Staff
3) Happier Client

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html