PEPPER MEDICARE PART A CLINICAL REVIEW

Quality Assessment and Assurance Program Review

FACILITY NAME:	REVIEW DATE: ____/____/_____	REVIEWER:	DATE: ____/____/_____	PERCENTILE:

Instructions: Y = YES N = NO N/A = Does not apply. Explain all "No" responses. Record action plan on page 2. <u>All reviews relate ONLY to traditional Medicare A.</u>

Resident Name						
HIC/MBI Number						
Resident first, [middle initial] and last name spelling match Medicare card, Face Sheet and MDS						
Admission date accurate on Face Sheet & MDS (A1600)						
First day of Medicare A stay accurate on MDS (A2400B)						
Date of birth (A0900), SSN (A0600A) and gender (A0800) accurate on Face Sheet and MDS						
Medicare number verified with common working file/HETS and is accurate						
Available Medicare Part A days verified						
3-day qualifying inpatient hospital stay verified						
Physician's Order(s) and Diagnosis(es) for skilled care complete, signed and dated						
Diagnoses are sequenced and coded accurately						
MDS ARD within allowable timeframes and match rehabilitation documentation						
RUG category matches MDS data and rehabilitation documentation						
MDS completed, transmitted timely and accepted						
AI/HIPPS modifier codes verified and accurate						
Therapy orders and plan of care obtained before treatment/therapy initiated Orders signed and dated by physician						
Therapy treatments signed and dated by licensed therapist						
Documented therapy days and minutes support MDS data						
Therapy progress notes completed, dated and signed weekly						
Was COT required? If so, was the COT completed timely?						
Was EOT or EOT-R required? If so, was the EOT or EOT-R completed timely?						
Orders for skilled nursing care obtained, signed and dated by physician						
Daily/weekly skilled care documentation completed timely and supports MDS data						
CNA documentation agrees with licensed documentation and MDS data						
Initial certification identifies skilled service(s). Completed timely. Signed and dated						
Record date of initial certification here						
Recertifications completed timely. Signed and dated						
Record recertification dates here						
Initial certification/recertification copies provided to Business Office Manager						
Expedited appeal notice presented timely and receipt signed						
Medicare non-coverage notice presented timely and receipt signed						

PEPPER MEDICARE PART A CLINICAL REVIEW: Target Areas and Action Plan

Quality Assessment and Assurance Program Review

FACILITY NAME:	REVIEW DATE: ____/____/_____	REVIEWER:

Instructions:

1. List residents with negative responses (from page 1)
2. Explain discrepancies
3. Document corrective action plan including responsible party/discipline, target resolution date and date resolved with signature and title

PEPPER Target Areas:
(Suggested intervention at/above 80th percentile * or at/below 20th percentile +):

- Therapy RUGs with High ADLs * +
- Non-therapy RUGs with High ADLs * +
- Change of Therapy Assessment *
- Ultrahigh Therapy RUGs *
- 90+ Day Episodes of Care *
- 20-Day Episodes of Care *

Resident Name	Explain Negative Audit Responses Related to PEPPER Target Areas	Corrective Action Plan	Responsible Party/Discipline	Target Resolution Date	Date Resolved Signature & Title

Route to:	Date Received:	Route to:	Date Received:
Administrator/Executive Director		Chief Operating/Chief Financial Officer	
Business Office Manager		Compliance Officer/QAAC Coordinator	
Director of Nursing		MDS Coordinator	

This document is prepared for review and analysis by the QAAC. The information in this review is **Confidential** and not to be copied or distributed without the written consent of the Administrator/Executive Director.