TRIPLE CHECK

INSTRUCTIONS: Review each item and select the appropriate observation. Record comments as needed. IDT members should sign and date. Retain completed form in the resident's Business Office file.

Reason for Triple Check: ❑ New admission ❑ Pre-Billing submission ❑ Interrupted Stay ❑ Interim Payment Assessment (IPA) ❑ Resident left AMA ❑ Resident expired ❑ Payment denied ❑ Audit ❑ ICD code questioned ❑ LOS < 20 days ❑ Other____________________

PART A		COMMENTS
Beneficiary Identifiers		
Name is correct	❍ Yes ❍ No	
DOB is correct	❍ Yes ❍ No	
Gender is correct	❍ Yes ❍ No	
MBI number is correct and confirmed	❍ Yes ❍ No	
Secondary insurance/other payer confirmed	❍ Yes ❍ No	
Date of admission correct	❍ Yes ❍ No	
Eligibility/available benefit days confirmed from HETS file	❍ Yes ❍ No	
Qualifying stay confirmed	❍ Yes ❍ No	
Facility/Provider Identifiers		
NPI number is correct	❍ Yes ❍ No	
CMS Certification Number (CCN) is correct	❍ Yes ❍ No	
MDS/Documentation/ Certifications/UB-04 Billing		
Admission date accurate/ matches on UB-04 and all MDS records	❍ Yes ❍ No	
Qualifying inpatient hospital stay dates accurate/match on UB-04 and medical records	❍ Yes ❍ No	
Physician certification and recertifications of need for SNF care complete, accurate and timely	❍ Yes ❍ No	
Admission orders, including SNF LOC, on medical record and signed	❍ Yes ❍ No	

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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TRIPLE CHECK

PART A		COMMENTS
MDS opened and ARD set within allowable time frame	❍ Yes ❍ No	
Interim Payment Assessment (IPA) ARD accurate and verified	❍ Yes ❍ No ❍ Not Applicable	
ARD accurate/matches UB-04	❍ Yes ❍ No	
BIMS Interview completed on/ before ARD; Staff Assessment for Mental Status if resident interview could not be completed (Section C)	❍ Yes ❍ No	
PHQ-9 Resident Mood Interview completed on/before ARD; Staff Assessment of Resident Mood if resident interview could not be completed (Section D)	❍ Yes ❍ No	
MDS Section GG coded accurately	❍ Yes ❍ No	
I0020B coded accurately	❍ Yes ❍ No	
I8000 coded accurately and properly sequenced	❍ Yes ❍ No	
All diagnoses coded in the MDS and UB-04 are documented by the physician in the resident's medical record; onset dates recorded	❍ Yes ❍ No	
B20 (HIV/AIDS) coded on UB-04, if applicable	❍ Yes ❍ No ❍ Not Applicable	
J2000-J5000 coded accurately	❍ Yes ❍ No	
K0110A-D, K0510A, K0510B, K0510C, K0710A and K0710B coded accurately	❍ Yes ❍ No	
O0100A-F, O0100H-J and O0100M While a Resident coded accurately	❍ Yes ❍ No	
O0425A, O0425B, O0425C and O0430 coded accurately	❍ Yes ❍ No	
O0500A-J coded accurately	❍ Yes ❍ No	
HIPPS code in UB-04 matches Z0100A	❍ Yes ❍ No	

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TRIPLE CHECK

IDT members signed Z0400	❍ Yes ❍ No	
RN Assessment Coordinator signed Z0500	❍ Yes ❍ No	
Interrupted stay(s) applicable during dates of service	❍ Yes ❍ No	
All PPS/MDS records submitted and accepted by QIES ASAP	❍ Yes ❍ No	
Therapy certifications/ recertifications are complete, accurate and signed	❍ Yes ❍ No	
Medical record documentation supports medical necessity, resident condition and services provided	❍ Yes ❍ No	
Resident's plan of care is accurate and complete	❍ Yes ❍ No	
Days billed each month is accurate	❍ Yes ❍ No	
Pharmacy charges are for legend drugs used during dates of service	❍ Yes ❍ No	
Laboratory charges are for legend services utilized during dates of service	❍ Yes ❍ No	
LOA days and dates are accurate on the UB-04 as well as supported in the resident's medical record	❍ Yes ❍ No ❍ Not Applicable	
Dates of service on UB-04 are correct	❍ Yes ❍ No	
Bill type on UB-04 is correct	❍ Yes ❍ No	
PART B ONLY		**COMMENTS**
Orders for therapy evaluation/ treatment signed by physician	❍ Yes ❍ No	
Plan of Care signed by physician	❍ Yes ❍ No	
Dates of service accurate and match therapy logs	❍ Yes ❍ No	
CPT codes accurate and match therapy logs	❍ Yes ❍ No	
Functional limitation (G codes) accurate	❍ Yes ❍ No	

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TRIPLE CHECK

Modifiers accurate	❍ Yes ❍ No	
Resident's name, DOB and MBI correct and confirmed from HETS file	❍ Yes ❍ No	
Physician name and NPI number accurate	❍ Yes ❍ No	
ABN		**COMMENTS**
Part A: CMS-10055 provided timely	❍ Yes ❍ No ❍ Not Applicable	
Part B: CMS-R-131 provided timely	❍ Yes ❍ No ❍ Not Applicable	
Part A and B: CMS-10123 provided timely	❍ Yes ❍ No ❍ Not Applicable	
CMS-10124 (DENC) - request for expedited review provided timely	❍ Yes ❍ No ❍ Not Applicable	

ADDITIONAL COMMENTS/ACTION PLAN, IF NEEDED

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SIGNATURES

I certify that I have reviewed and verified the information/documentation as needed for an accurate triple check.

Administrator:_______________________ Date:__________ Business Office Manager:_______________________ Date:__________

Therapy Rehab/Director:_______________________ Date:__________ MDS Coordinator:_______________________ Date:__________

Director of Nursing:_______________________ Date:__________ Reimbursement Specialist:_______________________ Date:__________

Other, specify title:_______________________ Date:__________ Other, specify title:_______________________ Date:__________