DRAFT UNDERPAYMENT FINDINGS

Sample No.	Subject Facility	Claim Date	Billed HIPPS	Audited HIPPS	Reason
[redacted]	[redacted]	03/22/2020-03/31/2020	KGSF1 10 Units	IDMF1 10 Units	The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 22 to 0 and the nursing function score from 16 to 0. The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition.
[redacted]	[redacted]	04/01/2020-04/19/2020	KGSF1 19 Units	IDMF1 19 Units	The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 22 to 0 and the nursing function score from 16 to 0.

Sample No.	Subject Facility	Claim Date	Billed HIPPS	Audited HIPPS	Reason
					The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition.
[redacted]	[redacted]	11/18/2019-11/30/2019	OJKD1 13 Units	OKKD1 13 Units	The medical record supports the coding of coughing or choking during meals and complaints of difficulty or pain with swallowing MDS Section K. The Registered Dietician assessment dated 11/20/2019 indicated swallowing difficulty, and "Res endorses some "chocking." This affects the SLP case mix. The medical record did not contain the SLP evaluation and plan of care that would be the basis for determining the reasonableness of the therapy provided. SLP services were not allowed without the evaluation.
[redacted]	[redacted]	12/01/2019-12/31/2019	OJKD1 31 Units	OKKD1 31 Units	The medical record supports the coding of coughing or choking during meals and complaints of difficulty or pain with swallowing MDS Section K. The Registered Dietician assessment dated 11/20/2019 indicated swallowing difficulty, and "Res endorses some "chocking." This affects the SLP case mix. The medical record did not contain the SLP evaluation and plan of care that would be the basis for determining the reasonableness of the therapy provided. SLP services were not allowed without the evaluation.

Sample No.	Subject Facility	Claim Date	Billed HIPPS	Audited HIPPS	Reason
[redacted]	[redacted]	01/01/2020-01/20/2020	OJKD1 19 Units	OKKD1 19 Units	The medical record supports the coding of coughing or choking during meals and complaints of difficulty or pain with swallowing MDS Section K. The Registered Dietician assessment dated 11/20/2019 indicated swallowing difficulty, and "Res endorses some "chocking." This affects the SLP case mix. The medical record did not contain the SLP evaluation and plan of care that would be the basis for determining the reasonableness of the therapy provided. SLP services were not allowed without the evaluation.
[redacted]	[redacted]	10/19/2019-10/31/2019	KBXE1 13 Units	KCXE1 13 Units	The medical record supports the coding of holding food in mouth/cheeks MDS Section K. This affects the SLP case mix. The SLP evaluation dated 10/20/2019 indicated oral residue with regular solids and regular ground.
[redacted]	[redacted]	11/01/2019-11/23/2019	KBXE1 22 Units	KCXE1 22 Units	The medical record supports the coding of holding food in mouth/cheeks MDS Section K. This affects the SLP case mix. The SLP evaluation dated 10/20/2019 indicated oral residue with regular solids and regular ground.
[redacted]	[redacted]	04/20/2020-04/30/2020	IDCD1 11 Units	JDCD1 11 Units	The documentation in the medical record does not support the coding in Section GG for oral hygiene and sit to lying. Based on the documentation the proper coding for the usual performance of the functional abilities is moderate assistance for oral hygiene and sit to lying. The corrected coding changes the PT and OT function score from 5 to 8 and the nursing function score from 5 to 6.

Sample No.	Subject Facility	Claim Date	Billed HIPPS	Audited HIPPS	Reason
[redacted]	[redacted]	05/01/2020-05/31/2020	IDCD1 31 Units	JDCD1 31 Units	The documentation in the medical record does not support the coding in Section GG for oral hygiene and sit to lying. Based on the documentation the proper coding for the usual performance of the functional abilities is moderate assistance for oral hygiene and sit to lying. The corrected coding changes the PT and OT function score from 5 to 8 and the nursing function score from 5 to 6.
[redacted]	[redacted]	06/01/2020-06/30/2020	IDCD1 30 Units	JDCD1 30 Units	The documentation in the medical record does not support the coding in Section GG for oral hygiene and sit to lying. Based on the documentation the proper coding for the usual performance of the functional abilities is moderate assistance for oral hygiene and sit to lying. The corrected coding changes the PT and OT function score from 5 to 8 and the nursing function score from 5 to 6.
[redacted]	[redacted]	07/01/2020-07/28/2020	IDCD1 27 Units	JDCD1 27 Units	The documentation in the medical record does not support the coding in Section GG for oral hygiene and sit to lying. Based on the documentation the proper coding for the usual performance of the functional abilities is moderate assistance for oral hygiene and sit to lying. The corrected coding changes the PT and OT function score from 5 to 8 and the nursing function score from 5 to 6.
[redacted]	[redacted]	02/12/2020-03/01/2020	KGXF1 18 Units	KHSE1 18 Units	The documentation in the medical record does not support the coding in Section GG for toileting, toilet transfer, and walk 150 feet. Based on the documentation the proper coding for the usual performance of the functional abilities is independent for toileting, toilet

Sample No.	Subject Facility	Claim Date	Billed HIPPS	Audited HIPPS	Reason
					transfer, and walk 150 feet. The corrected coding changes the PT and OT function score from 18 to 23 and the nursing function score from 14 to 15. The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the case mix group. The medical record supports the coding of morbid obesity, BMI >40. The documentation supports this diagnosis was active during the lookback period. This coding affects the NTA score. The auditor is unable to find documentation to support the concurrent therapy coded by OT. Although it is marked on the service grid, there is no documentation to meet the requirements of the RAI manual. The RAI Manual, Chapter 3 Section O states Concurrent therapy is defined as the treatment of two residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. The following OT minutes are not allowed: 10 minutes on 2/21/2020.
[redacted]	[redacted]	10/01/2019-10/18/2019	IEID0 17 Units	IFID0 17 Units	The medical record supports the coding of loss of liquids/solids from mouth and holding food in mouth/cheeks in MDS Section K. The SLP evaluation dated

Sample No.	Subject Facility	Claim Date	Billed HIPPS	Audited HIPPS	Reason
					10/4/2019 indicated anterior spillage with thin liquids and puree, and noted oral residue with chopped, ground and puree. This affects the SLP case mix.
[redacted]	[redacted]	03/22/2020-03/31/2020	JHXE1 10 Units	IHUD1 10 Units	The CMS benefit period waiver allows for additional Medicare coverage for beneficiaries who have begun but could not complete the 60-day break in the spell of illness. Medicare coverage for this resident was allowed under the CMS benefit waiver. The Subject Facility billed this Patient Stay as a continuation of the prior stay and not a new Medicare Patient Stay. As a result, the payment received by the Subject Facility is not accurate. The Subject Facility is in the process of correcting this claim. For the audit, LWCI will record the actual payment received as of the end of the Reporting Period. The audited payment will reflect the amount that should be paid following the rules set forth by CMS. The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 8 to 0 and the nursing function score from 7 to 0.

Sample No.	Subject Facility	Claim Date	Billed HIPPS	Audited HIPPS	Reason
					The medical record supports the coding of J80-Acute respiratory distress syndrome. The documentation supports this diagnosis was active during the lookback period. This coding affects the NTA comorbidity score.
[redacted]	[redacted]	04/01/2020-04/20/2020	JHXE1 20 Units	IHUD1 20 Units	The CMS benefit period waiver allows for additional Medicare coverage for beneficiaries who have begun but could not complete the 60-day break in the spell of illness. Medicare coverage for this resident was allowed under the CMS benefit waiver. The Subject Facility billed this Patient Stay as a continuation of the prior stay and not a new Medicare Patient Stay. As a result, the payment received by the Subject Facility is not accurate. The Subject Facility is in the process of correcting this claim. For the audit, LWCI will record the actual payment received as of the end of the Reporting Period. The audited payment will reflect the amount that should be paid following the rules set forth by CMS. The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT

Sample No.	Subject Facility	Claim Date	Billed HIPPS	Audited HIPPS	Reason
					function score from 8 to 0 and the nursing function score from 7 to 0. The medical record supports the coding of J80-Acute respiratory distress syndrome. The documentation supports this diagnosis was active during the lookback period. This coding affects the NTA comorbidity score.

DRAFT OVERPAYMENT FINDINGS

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
[redacted]	[redacted]	12/19/2019-12/31/2019	GGGD1 13 Units	FGGD1 13 Units	The documentation in the medical record does not support the coding in Section GG for walk 50 feet. Based on the documentation the proper coding for the usual performance of the functional abilities is not attempted due to the medical condition or safety concern for walk 50 feet. The documentation in the medical record does not support the coding in Section GG for walk 150 feet. Documentation is lacking to demonstrate the resident walked 150 feet during the first three admission days. Based on the documentation the proper coding for the usual performance of the functional abilities is not attempted and the resident did not perform this activity prior to the current illness. The corrected coding changes the PT and OT function score from 12 to 9 and the nursing function score is unchanged.	No Rebuttal	N/A
[redacted]	[redacted]	01/01/2020-01/02/2020	GGGD1 1 Units	FGGD1 1 Units	The documentation in the medical record does not support the coding in Section GG for walk 50 feet. Based on the documentation the proper coding for the usual	No Rebuttal	N/A

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					performance of the functional abilities is not attempted due to the medical condition or safety concern for walk 50 feet. The documentation in the medical record does not support the coding in Section GG for walk 150 feet. Documentation is lacking to demonstrate the resident walked 150 feet during the first three admission days. Based on the documentation the proper coding for the usual performance of the functional abilities is not attempted and the resident did not perform this activity prior to the current illness. The corrected coding changes the PT and OT function score from 12 to 9 and the nursing function score is unchanged.		
[redacted]	[redacted]	07/24/2020-07/31/2020	EGUE1 8 Units	JGXE1 8 Units	The primary diagnosis coded in I0020B is not supported by the physician documentation. The Subject Facility listed contracture of left hand as the primary diagnosis; no therapy services were provided. This is not the reason for the skilled care under Medicare. The SNF Initial Certification identifies the resident was exposed to COVID-19 7/24/2020 and tested positive on	No Rebuttal	N/A

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					7/28/2020. The primary reason for skilled care is to monitor respiratory systems. The documentation supports the coding of R09.89, Other specified symptoms and signs involving the circulatory and respiratory systems as the primary diagnosis for this Patient Stay. The change in diagnosis results in a change in the PT and OT category to the default clinical category of medical management. The documentation in the medical record does not support the coding in Section GG for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. Based on the documentation the proper coding for the usual performance of the functional abilities is moderate assistance for sit to lying, lying to sitting on side of bed, and sit to stand. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding of chair/bed-to-chair transfer, toilet transfer; therefore, the MDS is coded as missing information for these tasks. The corrected coding		

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]	[redacted] Rebuttal Response
					changes the PT and OT function score from 5 to 9 and the nursing function score from 4 to 7.		
[redacted]	[redacted]	10/14/2019-10/31/2019	CGGD1 18 Units	CDPD1 18 Units	The primary diagnosis coded in I0020B is not coded with the greatest specificity. The documentation supports the coding of S72.032D (displaced mid cervical fracture of left femur, subsequent encounter for closed fracture with routine healing) as the primary diagnosis for this Patient Stay, and not aftercare for the hip replacement. Per the ICD-10 coding manual, if the joint replacement was due to a fracture, you should code the fracture. Since J2310 (Hip Replacement) is appropriately checked on the MDS, this will track to the Major Joint Replacement category. The change in diagnosis does not change the payment. The diagnosis for CVA was indicated in Section I of the MDS. This resident had a history of CVA; however, the medical record does not support that this is an active diagnosis in the lookback period. Elimination of this diagnosis affects the SLP case mix group.	Rebuttal for SLP: The resident had a history of stroke according to hospital H&P (page 34). He continued to receive Aspirin daily as an active dx for CVA. (page 265, 378) Because of the ongoing medication management for stroke prevention, nurses continued monitoring for potential side effects from medication including signs and symptoms of bleeding, bruising in the last 7days (Care Plan pg213). See attached CareTracker daily skin check 10/14/19-10/18/19). Per RAI page I-12, If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease. Rebuttal for Nursing case mix: Please see the attached supporting documentation Note Report for SOB lying flat dated 10/16/2019	LWCI reviewed the rebuttal comments related to the coding of the CVA as an active diagnosis. The hospital physician documented History of stroke. There is no exact date, however "approximately 2007" is listed on the hospital record on page 24 of the PDF. The resident had been taking 1 aspirin per day as a home medication regime. The MAR on page 378 of the PDF records "aspirin for CVA prophylaxis". Prophylaxis refers to prevention and not an active diagnosis. In describing a CVA as an active diagnosis, the RAI Manual v1.17, October 2019, Chapter 3, page I-15 describes a recent stroke that has active treatment for residual deficits of the stroke and receiving therapy for those deficits. The PT and OT evaluations and plans of care do not include the diagnosis of stroke, or support any deficits related to a prior stroke. The care plan on page 213 of the PDF lists the recent

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]	[redacted] Rebuttal Response
					The medical record does not support the coding of shortness of breath when lying flat on the MDS. The documentation does not support this diagnosis was active during the lookback period. This coding affects the Nursing score.		hip surgical repair as the primary diagnosis. Monitoring for bleeding due to anticoagulation/antiplatelet therapy to prevent thrombosis or embolism would be more directly related to the immobility from the recent surgical repair than to a stroke that occurred in 2007. The history of stroke does not qualify as an active diagnosis and should not be considered as a SLP comorbidity. The audit finding stands. With regards to the rebuttal for the Nursing case mix: the supplemental Note Report from the modified MDS, ARD 10/18/2019, that was provided on 10/20/2020, was reviewed. This document, which is assumed to have been recorded by the MDS Coordinator, documents that the resident "complained of SOB when lying flat" during an interview. This same information was not documented by the nurses in the medical record. Since documentation was provided, it will be allowed. However,

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
							this Note Report should be included in the submitted medical record. The nursing finding is reversed. CDGD1 18 Units
[redacted]	[redacted]	11/01/2019-11/26/2019	CGGD1 25 Units	CDPD1 25 Units	The primary diagnosis coded in I0020B is not coded with the greatest specificity. The documentation supports the coding of S72.032D (displaced mid cervical fracture of left femur, subsequent encounter for closed fracture with routine healing) as the primary diagnosis for this Patient Stay, and not aftercare for the hip replacement. Per the ICD-10 coding manual, if the joint replacement was due to a fracture, you should code the fracture. Since J2310 (Hip Replacement) is appropriately checked on the MDS, this will track to the Major Joint Replacement category. The change in diagnosis does not change the payment. The diagnosis for CVA was indicated in Section I of the MDS. This resident had a history of CVA; however, the medical record does not support that this is an active diagnosis in the lookback period.	Rebuttal for SLP: The resident had a history of stroke according to hospital H&P (page 34). He continued to receive Aspirin daily as an active dx for CVA. (page 265, 378) Because of the ongoing medication management for stroke prevention, nurses continued monitoring for potential side effects from medication including signs and symptoms of bleeding, bruising in the last 7days (Care Plan pg213). See attached Care Tracker daily skin check 10/14/19-10/18/19). Per RAI page I-12, If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease. Rebuttal for Nursing case mix: Please see the attached supporting documentation	LWCI reviewed the rebuttal comments related to the coding of the CVA as an active diagnosis. The hospital physician documented History of stroke. There is no exact date, however "approximately 2007" is listed on the hospital record on page 24 of the PDF. The resident had been taking 1 aspirin per day as a home medication regime. The MAR on page 378 of the PDF records "aspirin for CVA prophylaxis". Prophylaxis refers to prevention and not an active diagnosis. In describing a CVA as an active diagnosis, the RAI Manual v1.17, October 2019, Chapter 3, page I-15 describes a recent stroke that has active treatment for residual deficits of the stroke and receiving therapy for those deficits. The PT and OT evaluations and plans of care do not include the diagnosis of stroke, or support any deficits related to a prior

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					Elimination of this diagnosis affects the SLP case mix group. The medical record does not support the coding of shortness of breath when lying flat on the MDS. The documentation does not support this diagnosis was active during the lookback period. This coding affects the Nursing score.	Note Report for SOB lying flat dated 10/16/2019	stroke. The care plan on page 213 of the PDF lists the recent hip surgical repair as the primary diagnosis. Monitoring for bleeding due to anticoagulation/antiplatelet therapy to prevent thrombosis or embolism would be more directly related to the immobility from the recent surgical repair than to a stroke that occurred in 2007. The history of stroke does not qualify as an active diagnosis and should not be considered as a SLP comorbidity. The audit finding stands. With regards to the rebuttal for the Nursing case mix: the supplemental Note Report from the modified MDS, ARD 10/18/2019, that was provided on 10/20/2020, was reviewed. This document, which is assumed to have been recorded by the MDS Coordinator, documents that the resident “complained of SOB when lying flat” during an interview. This same information was not documented by the nurses in the medical record. Since

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
							documentation was provided, it will be allowed. However, this Note Report should be included in the submitted medical record. The nursing finding is reversed. CDGD1 18 Units
[redacted]	[redacted]	07/24/2020-07/29/2020	OKCD1 5 Units	KHGD1 5 Units	The documentation does not support the criteria for coding isolation on the MDS. The RAI manual instructs to code for "single room isolation" only when all of the following conditions are met: 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate	Rebuttal for nursing case mix: Please see attached supporting documentation to support Extensive Services ES1 case mix for isolation. The resident met all the criteria for single room isolation, see below explanation: 1. The resident had active infection which showed on the attached lab result "Positive for Covid-19" on 7/27/20. She developed fever, CXR showed Rt Lower Lobe Pneumonia. She was on antibiotic therapy for respiratory infection related to covid-19. See page 232 2. Physician ordered droplet/contact single room isolation on 7/27/20 due to positive for covid-19 see page 183 3. The resident remained in the single room isolation alone by herself and not cohorted with a roommate. 4. All activities and care were	LWCI reviewed the uploaded COVID-19 test dated 7/27/2020. The criteria for coding of isolation was not a dispute of the active infection but the fact that documentation does not support that the resident stayed in the room. The CNA ADL tracker on page 360 documents that the resident walked in the corridor on 7/27/2020 and 7/28/2020. Locomotion off the unit was marked 7/28/2020. The coding of "0,0" per the RAI Manual means "independent, with no physical set up or help". The CNA "D" coded 0,0. The coding of "8,8" means that the activity did not occur. The audit findings stands.

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					regardless of whether the roommate has a similar active infection that requires isolation. 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.). On 7/24/2020, the CNA ADL tracker codes extensive assistance of one for Locomotion Off Unit, which indicates resident was not treated in room. This does not meet the requirement for coding isolation. The primary diagnosis coded in I0020B is not supported by the physician documentation. The documentation supports the coding of R09.89, other specified symptoms and signs involving the circulatory and respiratory systems as the primary diagnosis for this Patient Stay. The resident's Medicare coverage was based on their exposure to COVID-19 and the physician order to monitor respiratory systems. The diagnosis to support the SNF coverages is mapped to the default clinical category of Medical Management.	rendered inside the room from 7/27/20, the date that the resident tested positive until 7/29/20 the ARD date of MDS 5-day PPS. Locomotion OFF UNIT and Walk in the hall were documented as did not happen. See page 360 On 7/24/20, the resident was negative for Covid (page 388). The single room isolation was ordered by Physician due to positive Covid -19 result on 7/27/20. Please see attached supporting document – CNA ADL flowsheet indicated that the locomotion off unit from 7/27/20 until 7/29/20 (discharged to acute hospital), did not happen. See page 360.	

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
[redacted]	[redacted]	01/17/2020-01/31/2020	OLKC1 15 Units	OKKD1 15 Units	The medical record does not support the coding of complaints of difficulty or pain with swallowing on the MDS in Section K. The swallowing problem was noted in the Registered Dietician assessment on 1/24/2020, which is after the ARD on 1/21/2020. The SLP evaluation dated 1/20/2020 indicated swallow skills are within functional limits (WFL). This coding change affects the SLP case mix group. The medical record does not support the diagnosis coding of malnutrition. The hospital notes indicate the resident is "well nourished". There is documentation in care plan and in SLP note regarding "to prevent" malnutrition; however, the physician has not documented malnutrition as an active diagnosis. The documentation does not support this diagnosis was active during the lookback period. This coding affects the NTA comorbidity score.	Rebuttal for NTA case mix: The resident was admitted on 1/17/20 with multiple medical complex comorbidities, decondition and poor cognition that put resident at risk for Malnutrition. Per hospital lab on 1/11/20 res Albumin level was low at 2.6 g/dL with normal range of 3.3-4.8 g/dL and Albumin Globulin Ration 0.6 with normal range of 1.0-1.9 ratio. Excessive consumption of alcohol has lasting effects on the nutritional resources in the body and tend to be more prone to nutritional deficiencies. Although there was no active dx for Malnutrition, the resident remained AT RISK FOR MALNUTRITION, and that was the reason for coding Malnutrition in Section I5600. Dasarathy S. (2016). Nutrition and Alcoholic Liver Disease: Effects of Alcoholism on Nutrition, Effects of Nutrition on Alcoholic Liver Disease, and Nutritional Therapies for Alcoholic Liver Disease. Clinics in liver disease, 20(3), 535–550.	N/A

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
						https://doi.org/10.1016/j.cld.2016.02.010	
[redacted]	[redacted]	02/01/2020-02/26/2020	OLKC1 25 Units	OKKD1 25 Units	The medical record does not support the coding of complaints of difficulty or pain with swallowing on the MDS in Section K. The swallowing problem was noted in the Registered Dietician assessment on 1/24/2020, which is after the ARD on 1/21/2020. The SLP evaluation dated 1/20/2020 indicated swallow skills are within functional limits (WFL). This coding change affects the SLP case mix group. The medical record does not support the diagnosis coding of malnutrition. The hospital notes indicate the resident is "well nourished". There is documentation in care plan and in SLP note regarding "to prevent" malnutrition; however, the physician has not documented malnutrition as an active diagnosis. The documentation does not support this diagnosis was active during the lookback period. This coding affects the NTA comorbidity score.	Rebuttal for NTA case mix: The resident was admitted on 1/17/20 with multiple medical complex comorbidities, decondition and poor cognition that put resident at risk for Malnutrition. Per hospital lab on 1/11/20 res Albumin level was low at 2.6 g/dL with normal range of 3.3-4.8 g/dL and Albumin Globulin Ration 0.6 with normal range of 1.0-1.9 ratio. Excessive consumption of alcohol has lasting effects on the nutritional resources in the body and tend to be more prone to nutritional deficiencies. Although there was no active dx for Malnutrition, the resident remained AT RISK FOR MALNUTRITION, and that was the reason for coding Malnutrition in Section I5600. Dasarathy S. (2016). Nutrition and Alcoholic Liver Disease: Effects of Alcoholism on Nutrition, Effects of Nutrition on Alcoholic Liver Disease, and Nutritional Therapies for	LWCI reviewed the rebuttal statement to support the efficacy of coding malnutrition to support the NTA coding. Per the RAI Manual, Chapter 3, Section I: Active Diagnoses, page I-7, The disease conditions in this section require a **physician-documented diagnosis** (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. When the Interdisciplinary team identifies inherent risk, the physician must be notified to obtain a diagnosis, if the physician agrees. The requirement for diagnosis coding starts with the physician diagnosis. The audit finding stands.

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
						Alcoholic Liver Disease. Clinics in liver disease, 20(3), 535–550. https://doi.org/10.1016/j.cld.2016.02.010	
[redacted]	[redacted]	01/07/2020-01/27/2020	KCGD1 21 Units	KCXD1 21 Units	The medical record does not support the coding of shortness of breath when lying flat. The documentation does not support this condition was active during the lookback period. This coding change affects the Nursing score.	Please see the supporting documentation for SOB while lying flat which was charted on Note Report dated 1/10/20 (ARD)	LWCI reviewed the supplemental Note Report from the modified MDS, ARD 1/10/2020, that was provided on 10/20/2020. This document, which is assumed to have been recorded by the MDS Coordinator, documents that the resident "complained of SOB when lying flat" during the interview, and per staff, nurses, and "this writer's observation". This same information was not documented by the nurses in the medical record. Since documentation was provided, it will be allowed. However, this Note Report should be included in the original medical record. The audit finding is reversed.
[redacted]	[redacted]	10/04/2019-10/31/2019	KGGF1 28 Units	KAGF1 28 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as	Rebuttal for SLP case mix: BIMS: Please see attached supporting documentation for BIMS dated 10/5/20. The BIMS worksheet was utilized for the interview, signed, and dated on the day of the interview was	LWCI reviewed the BIMS worksheet that was uploaded on 10/20/2020. The documentation supports the coding on the MDS for a cognitive impairment.

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					normal cognition. The coding change impacts the SLP case mix group. MDS Section I was coded for MDS Item I4500 CVA, left thalamus, without residual deficits. The medical record does not support that this is an active diagnosis in the lookback period. The revised coding in Section I affects the SLP case mix group.	conducted. CVA: The resident had a history of CVA of left thalamus according to hospital H&P (page 28,302). He continued to receive Aspirin daily as an active dx for CVA. (page 581) Because of the ongoing medication management for stroke prevention, nurses continued monitoring for potential side effects from medication including signs and symptoms of bleeding, bruising (Care Plan pg 199,200). See attached CareTracker daily skin check during the look back period 10/04/19-10/05/19).	LWCI reviewed the rebuttal comments related to the coding of the CVA as an active diagnosis. The hospital physician documented History of stroke. There is no exact date documented. The resident had been taking aspirin as a home medication regime. The MAR on p. 553 records “aspirin for CVA prophylaxis”. Prophylaxis refers to prevention and not an active diagnosis. In describing a CVA as an active diagnosis, the RAI Manual v1.17, October 2019, Chapter 3, p. I-15 describes a recent stroke that has active treatment for residual deficits of the stroke and receiving therapy for those deficits. The PT, OT and SLP evaluations and plans of care do not include the diagnosis of stroke, or support any deficits related to a prior stroke. The history of stroke does not qualify as an active diagnosis and should not be considered as a SLP comorbidity. The audit finding for CVA coding stands.

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
							The audit finding is modified to KDGF1 28 Units.
[redacted]	[redacted]	11/01/2019-11/13/2019	KGGF1 12 Units	KAGF1 12 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition. The coding change impacts the SLP case mix group. MDS Section I was coded for MDS Item I4500 CVA, left thalamus, without residual deficits. The medical record does not support that this is an active diagnosis in the lookback period. The revised coding in Section I affects the SLP case mix group.	Rebuttal for SLP case mix: BIMS: Please see attached supporting documentation for BIMS dated 10/5/20. The BIMS worksheet was utilized for the interview, signed, and dated on the day of the interview was conducted. CVA: The resident had a history of CVA of left thalamus according to hospital H&P (page 28,302). He continued to receive Aspirin daily as an active dx for CVA. (page 581) Because of the ongoing medication management for stroke prevention, nurses continued monitoring for potential side effects from medication including signs and symptoms of bleeding, bruising (Care Plan pg 199,200). See attached CareTracker daily skin check during the look back period 10/04/19-10/05/19). Per RAI page I-12, If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic	LWCI reviewed the BIMS worksheet that was uploaded on 10/20/2020. The documentation supports the coding on the MDS for a cognitive impairment. LWCI reviewed the rebuttal comments related to the coding of the CVA as an active diagnosis. The hospital physician documented History of stroke. There is no exact date documented. The resident had been taking aspirin as a home medication regime. The MAR on p. 553 records "aspirin for CVA prophylaxis". Prophylaxis refers to prevention and not an active diagnosis. In describing a CVA as an active diagnosis, the RAI Manual v1.17, October 2019, Chapter 3, p. I-15 describes a recent stroke that has active treatment for residual deficits of the stroke and receiving therapy for those deficits. The PT, OT and SLP evaluations and plans of care do not include the

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
						efficacy), then the prescription of the medication would indicate active disease.	diagnosis of stroke, or support any deficits related to a prior stroke. The history of stroke does not qualify as an active diagnosis and should not be considered as a SLP comorbidity. The audit finding for CVA coding stands. The audit finding is modified to KDGF1 12 Units.
[redacted]	[redacted]	07/24/2020-07/31/2020	OGGD1 8 Units	KDGD1 8 Units	The primary diagnosis coded in I0020B is not supported by the physician documentation. The documentation supports the coding of R09.89, other specified symptoms and signs involving the circulatory and respiratory systems as the primary diagnosis for this Patient Stay. The resident's Medicare coverage was based on their exposure to COVID-19 and the physician order to monitor respiratory systems. The diagnosis to support the SNF coverages is mapped to the default clinical category of Medical Management.	No Rebuttal	N/A
[redacted]	[redacted]	07/24/2020-07/31/2020	MKMF1 8 Units	IHMF1 8 Units	The primary diagnosis coded in I0020B is not supported by the	No Rebuttal	N/A

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					physician documentation. The documentation supports the coding of R09.89, other specified symptoms and signs involving the circulatory and respiratory systems as the primary diagnosis for this Patient Stay. The resident's Medicare coverage was based on their exposure to COVID-19 and the physician order to monitor respiratory systems. The diagnosis to support the SNF coverages is mapped to the default clinical category of Medical Management.		
[redacted]	[redacted]	03/30/2020-03/31/2020	GGGD1 2 Units	GDGE1 2 Units	MDS Section I was coded for the presence of a speech related comorbidity. The medical record indicated history of CVA, but it is no longer an active diagnosis. PT and OT evaluations show no strength differentiation left to right. The medical record does not support that this is an active diagnosis in the lookback period. The revised coding in Section I affects the SLP case mix group. The medical record does not support the coding of malnutrition. The physician did not document malnutrition. There is a care plan to monitor for signs and symptoms, but no physician	Rebuttal for SLP case mix: The resident had a history of ischemic right and left MCA stroke. He continued to receive ASA 81 mg daily and Plavix 75mg for stroke prevention as an active dx for CVA. (page287, 291) Because of the ongoing medication management for stroke prevention, nurses continued monitoring for potential side effects from medication including signs and symptoms of bleeding, bruising in the last 7days. See attached CareTracker daily skin check 3/30/20-4/2/20. Per RAI page I-12, If a medication is	LWCI reviewed the rebuttal comments related to the coding of the CVA as an active diagnosis. The hospital physician documented History of stroke. There is no exact date documented. The MAR on p. 683 records “aspirin for CVA prophylaxis”. Prophylaxis refers to prevention and not an active diagnosis. In describing a CVA as an active diagnosis, the RAI Manual v1.17, October 2019, Chapter 3, p. I-15 describes a recent stroke that has active treatment for residual deficits of the stroke and receiving therapy for those deficits. The

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Holding Rebuttal	[redacted] Rebuttal Response
					documentation of malnutrition. There is no evidence of malnutrition in the Registered Dietician documentation. The documentation does not support this diagnosis was active during the lookback period. This coding affects the NTA score.	prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.	PT and OT evaluations and plans of care include the diagnosis cerebrovascular disease, history of with no residual effects. The documentation does not describe ant residual effects for treatment, or support any deficits related to a prior stroke. The history of stroke does not qualify as an active diagnosis and should not be considered as a SLP comorbidity. The audit finding for CVA coding stands.
[redacted]	[redacted]	04/01/2020-04/30/2020	GGGD1 30 Units	GDGE1 30 Units	MDS Section I was coded for the presence of a speech related comorbidity (CVA). The medical record indicated history of CVA, but it is no longer an active diagnosis. PT and OT evaluations show no strength differentiation left to right. The medical record does not support that this is an active diagnosis in the lookback period. The revised coding in Section I affects the SLP case mix group. The medical record does not support the coding of malnutrition. The physician did	Rebuttal for SLP case mix: The resident had a history of ischemic right and left MCA stroke. He continued to receive ASA 81 mg daily and Plavix 75mg for stroke prevention as an active dx for CVA. (page287, 291) Because of the ongoing medication management for stroke prevention, nurses continued monitoring for potential side effects from medication including signs and symptoms of bleeding, bruising in the last 7days. See attached CareTracker daily skin check 3/30/20-4/2/20. Per RAI page I-	LWCI reviewed the rebuttal comments related to the coding of the CVA as an active diagnosis. The hospital physician documented History of stroke. There is no exact date documented. The MAR on p. 683 records "aspirin for CVA prophylaxis". Prophylaxis refers to prevention and not an active diagnosis. In describing a CVA as an active diagnosis, the RAI Manual v1.17, October 2019, Chapter 3, p. I-15 describes a recent stroke that has active treatment for residual deficits of the stroke and receiving

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					not document malnutrition. There is a care plan to monitor for signs and symptoms, but no physician documentation of malnutrition. There is no evidence of malnutrition in the Registered Dietician documentation. The documentation does not support this diagnosis was active during the lookback period. This coding affects the NTA score.	12, If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.	therapy for those deficits. The PT and OT evaluations and plans of care include the diagnosis cerebrovascular disease, history of with no residual effects. The documentation does not describe ant residual effects for treatment, or support any deficits related to a prior stroke. The history of stroke does not qualify as an active diagnosis and should not be considered as a SLP comorbidity. The audit finding for CVA coding stands.
[redacted]	[redacted]	07/24/2020-07/31/2020	KDXC1 8 Units	KDXD1 8 Units	The primary diagnosis coded in MDS Item I0020B is not supported by the physician documentation. The documentation supports the coding of R09.89, other specified symptoms and signs involving the circulatory and respiratory systems as the primary diagnosis for this Patient Stay. The resident's Medicare coverage was based on their exposure to COVID-19 and the physician order to monitor respiratory systems. The diagnosis to support the SNF coverages is mapped to the	Rebuttal for NTA case mix: Malnutrition is often caused by combination of physical, social, and psychological issues. During the resident hospitalization, several lab works were done that showed low in Albumin result= 2.9, Albumin Globulin Ration=0.6 which is below the normal limits, Hemoglobin=7.4 (pages 19, 524). He may not have the Malnutrition diagnosis, but because of his multiple medical condition including Developmental Delay, COPD,	LWCI reviewed the rebuttal statement to support the efficacy of coding malnutrition to support the NTA coding. Per the RAI Manual, Chapter 3, Section I: Active Diagnoses, page I-7, The disease conditions in this section require a **physician-documented diagnosis** (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. When the Interdisciplinary team identifies

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					default clinical category of Medical Management. The medical record does not support the coding of malnutrition. The physician has not documented this diagnosis. The documentation does not support this diagnosis was active during the lookback period. This coding affects the NTA score.	Chronic Anemia (page 12), those diagnoses have contributed to the reason why the resident was AT RISK FOR MALNUTRITION.	inherent risk, the physician must be notified to obtain a diagnosis, if the physician agrees. The requirement for diagnosis coding starts with the physician diagnosis. The audit finding stands.
[redacted]	[redacted]	07/24/2020-07/31/2020	NHIE1 8 Units	JEIE1 8 Units	The primary diagnosis coded in MDS Item I0020B is not supported by the physician documentation. The documentation supports the coding of R09.89, other specified symptoms and signs involving the circulatory and respiratory systems as the primary diagnosis for this Patient Stay. The resident's Medicare coverage was based on their exposure to COVID-19 and the physician order to monitor respiratory systems. The diagnosis to support the SNF coverages is mapped to the default clinical category of Medical Management.	No Rebuttal	N/A
[redacted]	[redacted]	05/21/2020-05/31/2020	KDFE1 11 Units	KDFF1 11 Units	The medical record does not support the coding of malnutrition. The physician has not documented malnutrition as an active diagnosis. The	Rebuttal for NTA case mix: Please see attached documentation to support that the resident is AT RISK for Malnutrition	LWCI reviewed Mini-Nutritional Assessment that was uploaded on 10/20/2020 to demonstrate the risk of malnutrition and support the efficacy of coding

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					documentation does not support this diagnosis was active during the lookback period. This coding affects the NTA comorbidity score.		malnutrition for the NTA coding. Per the RAI Manual, Chapter 3, Section I: Active Diagnoses, page I-7, The disease conditions in this section require a **physician-documented diagnosis** (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. When the Interdisciplinary team identifies inherent risk, the physician must be notified to obtain a diagnosis, if the physician agrees. The requirement for diagnosis coding starts with the physician diagnosis. The audit finding stands.
[redacted]	[redacted]	06/01/2020-06/30/2020	KDFE1 30 Units	KDFF1 30 Units	The medical record does not support the coding of malnutrition. The physician has not documented malnutrition as an active diagnosis. The documentation does not support this diagnosis was active during the lookback period. This coding affects the NTA comorbidity score.	Rebuttal for NTA case mix: Please see attached documentation to support that the resident is AT RISK for Malnutrition	LWCI reviewed Mini-Nutritional Assessment that was uploaded on 10/20/2020 to demonstrate the risk of malnutrition and support the efficacy of coding malnutrition for the NTA coding. Per the RAI Manual, Chapter 3, Section I: Active Diagnoses, page I-7, The disease conditions in this section require a **physician-documented diagnosis** (or by a nurse practitioner, physician

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted]
							assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. When the Interdisciplinary team identifies inherent risk, the physician must be notified to obtain a diagnosis, if the physician agrees. The requirement for diagnosis coding starts with the physician diagnosis. The audit finding stands.
[redacted]	[redacted]	07/01/2020-07/31/2020	KDFE1 31 Units	KDFF1 31 Units	The medical record does not support the coding of malnutrition. The physician has not documented malnutrition as an active diagnosis. The documentation does not support this diagnosis was active during the lookback period. This coding affects the NTA comorbidity score.	Rebuttal for NTA case mix: Please see attached documentation to support that the resident is AT RISK for Malnutrition	LWCI reviewed Mini-Nutritional Assessment that was uploaded on 10/20/2020 to demonstrate the risk of malnutrition and support the efficacy of coding malnutrition for the NTA coding. Per the RAI Manual, Chapter 3, Section I: Active Diagnoses, page I-7, The disease conditions in this section require a **physician-documented diagnosis** (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. When the Interdisciplinary team identifies inherent risk, the physician must be notified to obtain a diagnosis, if the physician

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
							agrees. The requirement for diagnosis coding starts with the physician diagnosis. The audit finding stands.
[redacted]	[redacted]	10/01/2019-10/21/2019	GGXF0 21 Units	GDXF0 21 Units	MDS Section I was coded for CVA. The medical record does not support that this is an active diagnosis in the lookback period. Although the physician H &P dates 8/5/2019 lists I63.9 stroke, this diagnosis is not supported by recent hospital documentation, which indicates calcaneal fracture, history of stroke denies residual motor deficits. The PT eval does not include stroke. The OT eval notes history of CVA only. The CVA diagnosis is not listed on the UB-04. The revised coding in Section I affects the SLP case mix group.	Rebuttal for SLP case mix: The resident had a history of stroke according to hospital H&P (page 19) and SNF Doctor's progress notes (page140). Because of the stroke, the resident was walking on her tip toes that resulted from the fall and sustained right heel fracture. She continued to receive ASA 81 mg daily for stroke prevention as an active dx for CVA. Because of the ongoing medication management for stroke prevention, nurses continued monitoring for potential side effects from Aspirin including signs and symptoms of bleeding, bruising in the last 3 day look back period. See attached CareTracker daily skin check 10/1/19-10/3/19 Per RAI page I-12, If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic	LWCI reviewed the rebuttal comments related to the coding of the CVA as an active diagnosis. The hospital physician and the SNF physician both document History of stroke. There is no exact date documented. The MAR on p. 290 records "aspirin for CVA prophylaxis". Prophylaxis refers to prevention and not an active diagnosis. In describing a CVA as an active diagnosis, the RAI Manual v1.17, October 2019, Chapter 3, p. I-15 describes a recent stroke that has active treatment for residual deficits of the stroke and receiving therapy for those deficits. The PT evaluation does not include a stroke and the OT evaluation uses the diagnosis cerebrovascular disease, history of with no residual effect. The documentation does not describe any residual effects for treatment, or support any deficits related to

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
						efficacy), then the prescription of the medication would indicate active disease.	a prior stroke. Although there is documentation that the patient "relates that because of her stroke she walks on her tip toes with a walker and the assistance of her husband", this cannot be verified. The OT documented in the evaluation "significant Achilles contracture". The focus of the therapy was not on the residual effects of the stroke but on the calcaneal fracture. The history of stroke does not qualify as an active diagnosis and should not be considered as a SLP comorbidity. The audit finding stands.
[redacted]	[redacted]	07/24/2020-07/31/2020	MKMD1 8 Units	JHMD1 8 Units	The primary diagnosis coded in I0020B is not supported by the physician documentation. The MDS recorded CVA as the primary diagnosis. The resident is covered under Medicare Part A on 7/24/20 because the resident requires close monitoring for Covid-19 symptoms. On 7/28/20 the resident Covid-19 test was positive (the week prior it had been negative). The documentation supports the coding of R09.89, Other specified symptoms and signs involving the	No Rebuttal	N/A

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					circulatory and respiratory systems, as the primary diagnosis for this Patient Stay. The change in diagnosis results in a change in the default clinical category to Medical Management. The documentation in the medical record does not support the coding in Section GG for eating. Based on the documentation the proper coding for the usual performance of the functional abilities is independent for eating. The corrected coding changes the PT and OT function score from 5 to 6 and the nursing function score from 4 to 5.		
[redacted]	[redacted]	07/24/2020-07/31/2020	HDYD1 8 Units	LDYD1 8 Units	The primary diagnosis coded in I0020B is not supported by the physician documentation. The resident is covered under Medicare Part A because the resident requires close monitoring for Covid-19 symptoms. The documentation supports the coding of R09.89, Other specified symptoms and signs involving the circulatory and respiratory systems, as the primary diagnosis for this Patient Stay. The change in diagnosis results in a change in the default clinical category to Medical Management. The	No Rebuttal	N/A

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
					audited HIPPS is based on the new default clinical category.		
[redacted]	[redacted]	11/01/2019-11/05/2019	GAGC1 4 Units	GAGC1 3 Units	The Detailed Census Report indicates three days were covered under Medicare Part A at a HIPPS of GAGC1. The census indicated 11/4/2019 was a private pay day. The November 2019 UB-04 billed 4 days at GAGC1. The SNF Certification form indicates the resident's last covered day is 11/4/19; however, LWCI is unable to resolve the conflict and three days are allowed.	Rebuttal for one day HIPPS: Please see attached supporting documents from KNS and PCC Census Reports. There was a software transitioned error from KNS to PCC. The last day of Medicare coverage was November 4, 2019. Please see attached NOMNC issued to the resident prior to discharge home with the Last Medicare Coverage dated 11/04/2019	LWCI reviewed the updated Census Days Report November 2019, PCC Detailed Census Report, and NOMNC LCD 11/4/2020 that were uploaded on 10/20/2020. These documents supported the claim days. The audit finding is reversed.
[redacted]	[redacted]	10/22/2019-10/31/2019	GDKE1 10 Units	GAXE1 10 Units	MDS Section I was coded for CVA. The medical record does not support that this is an active diagnosis in the lookback period. Documentation supports history of CVA. The revised coding in Section I affects the SLP case mix group. MDS Section I was coded for Parkinson's Disease. The medical record indicated that the resident did not have Parkinson's disease, but Parkinsonism signs due to drugs ("neuroleptics, better with cessation"). The revised coding in Section I affects the Nursing case mix group.	No Rebuttal	N/A

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted] Rebuttal	[redacted] Rebuttal Response
[redacted]	[redacted]	11/01/2019-11/28/2019	GDKE1 28 Units	GAXE1 28 Units	MDS Section I was coded for CVA. The medical record does not support that this is an active diagnosis in the lookback period. Documentation supports history of CVA. The revised coding in Section I affects the SLP case mix group. MDS Section I was coded for Parkinson's Disease. The medical record indicated that the resident did not have Parkinson's disease, but Parkinsonism signs due to drugs ("neuroleptics, better with cessation"). The revised coding in Section I affects the Nursing case mix group.	No Rebuttal	N/A
[redacted]	[redacted]	11/05/2019-11/30/2019	CDPE1 25 Units	CAPE1 25 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	Rebuttal for SLP case mix: Please see attached documentation to support the interview for Section C in MDS. The attached worksheet was completed and dated on the ARD November 8, 2019.	LWCI reviewed the BIMS worksheet that was uploaded on 10/20/2020. The documentation supports the coding on the MDS for a cognitive impairment. The audit finding is reversed.

DRAFT OVERPAYMENT FINDINGS

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
[redacted]	[redacted]	03/13/2020-03/31/2020	JDUE1 19 Units	IAUF1 19 Units	The CMS benefit period waiver allows for additional Medicare coverage for beneficiaries who have begun but could not complete the 60-day break in the spell of illness. Medicare coverage for this resident was allowed under the CMS benefit waiver. The Subject Facility billed this Patient Stay as a continuation of the prior stay and not a new Medicare Patient Stay. As a result, the payment received by the Subject Facility is not accurate. The Subject Facility is in the process of correcting this claim. For the audit, LWCI will record the actual payment received as of the end of the Reporting Period. The audited payment will reflect the amount that should be paid following the rules set forth by CMS. The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer,	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					walk 50 feet, and walk 150 feet. Based on the documentation the proper coding for the usual performance of the functional abilities is coded as a dash (-) for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 8 to 0 and the nursing function score from 5 to 0. The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					The medical record does not support the coding of morbid obesity. This diagnosis was documented by the physician on 4/7/2020 and 5/26/2020, after the 3/20/2020 ARD. The documentation does not support this diagnosis was active during the lookback period.	
[redacted]	[redacted]	04/01/2020-04/30/2020	JDUE1 30 Units	IAUF1 26 units	The CMS benefit period waiver allows for additional Medicare coverage for beneficiaries who have begun but could not complete the 60-day break in the spell of illness. Medicare coverage for this resident was allowed under the CMS benefit waiver. The Subject Facility billed this Patient Stay as a continuation of the prior stay and not a new Medicare Patient Stay. As a result, the payment received by the Subject Facility is not accurate. The Subject Facility is in the process of correcting this claim. For the audit, LWCI will record the actual payment received as of the end of the Reporting Period. The audited payment will reflect the amount	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					that should be paid following the rules set forth by CMS. The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. Based on the documentation the proper coding for the usual performance of the functional abilities is coded as a dash (-) for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 8 to 0 and the nursing function score from 5 to 0.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group. The medical record does not support the coding of morbid obesity. This diagnosis was documented by the physician on 4/7/2020 and 5/26/2020, after the 3/20/2020 ARD. The documentation does not support this diagnosis was active during the lookback period. Available CDC data indicates that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset. Persons with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset. Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					specimens for up to 3 months after illness onset, but at concentrations considerably lower than during illness, in ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely. This patient tested positive for COVID-19 on 3/13/2020 and exhibited mild to moderate symptoms. The physician notes indicated positive COVID-19, medication changes, and the exacerbation of condition should be monitored; however, observation and assessment are skilled services when the likelihood of change in a resident's condition requires skilled nursing personnel to identify and evaluate the resident's need for possible modification of treatment or initiation of additional medical procedures, until the resident's condition is essentially stabilized. The physician note dated 4/27/2020 indicated, "Acute lower respiratory infection. COVID POSITIVE. Stable." As of 4/27/2020, this resident was	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					stabilized. The documentation does not support that the resident required daily skilled nursing services. The April 2020 and May 2020 UB-04 listed PT and OT services, but there was no therapy documentation provided for this stay to support skilled rehabilitation services. The last covered day for Medicare Part A is 4/26/2020.	
[redacted]	[redacted]	05/01/2020-05/27/2020	JDUE1 27 Units	IAUF1 0 Units	The CMS benefit period waiver allows for additional Medicare coverage for beneficiaries who have begun but could not complete the 60-day break in the spell of illness. Medicare coverage for this resident was allowed under the CMS benefit waiver. The Subject Facility billed this Patient Stay as a continuation of the prior stay and not a new Medicare Patient Stay. As a result, the payment received by the Subject Facility is not accurate. The Subject Facility is in the process of correcting this claim. For the audit, LWCI will record the actual payment received as of the end of the Reporting Period. The audited payment will reflect the amount	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					that should be paid following the rules set forth by CMS. The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. Based on the documentation the proper coding for the usual performance of the functional abilities is coded as a dash (-) for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 8 to 0 and the nursing function score from 5 to 0.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group. The medical record does not support the coding of morbid obesity. This diagnosis was documented by the physician on 4/7/2020 and 5/26/2020, after the 3/20/2020 ARD. The documentation does not support this diagnosis was active during the lookback period. Available CDC data indicates that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset. Persons with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset. Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					specimens for up to 3 months after illness onset, but at concentrations considerably lower than during illness, in ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely. This patient tested positive for COVID-19 on 3/13/2020 and exhibited mild to moderate symptoms. The physician notes indicated positive COVID-19, medication changes, and the exacerbation of condition should be monitored; however, observation and assessment are skilled services when the likelihood of change in a resident's condition requires skilled nursing personnel to identify and evaluate the resident's need for possible modification of treatment or initiation of additional medical procedures, until the resident's condition is essentially stabilized. The physician note dated 4/27/2020 indicated, "Acute lower respiratory infection. COVID POSITIVE. Stable." As of 4/27/2020, this resident was	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					stabilized. The documentation does not support that the resident required daily skilled nursing services. The April 2020 and May 2020 UB-04 listed PT and OT services, but there was no therapy documentation provided for this stay to support skilled rehabilitation services. The last covered day for Medicare Part A is 4/26/2020.	
[redacted]	[redacted]	02/16/2020-02/18/2020	KDCD1 2 Units	KDXE1 2 Units	The documentation does not support the criteria for coding isolation on the MDS. The RAI manual instructs to code for "single room isolation" only when all of the following conditions are met: 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.). On the ADL flow sheet covering the lookback period, the resident had extensive assistance for self-performance and one person physical assist for support when walking in the corridor, locomotion on unit (how the resident moves between locations in her room and adjacent corridor on same floor), and locomotion off unit (how the resident moves to and returns from off-unit locations). The 2/18/2020 nursing progress note indicated, the resident is wandering and tried to go	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					outside. The documentation supports the , resident was not treated in room, as required for isolation coding.	
[redacted]	[redacted]	10/14/2019-10/31/2019	CBPE1 18 Units	CAPE1 18 Units	The medical record does not support the coding of a mechanically altered diet on the MDS in Section K. A mechanically altered diet is specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. The resident has orders for a regular texture diet with thin liquids. This diet is recommended by the SLP. The change in coding affects the SLP case mix group.	
[redacted]	[redacted]	11/01/2019-11/07/2019	CBPE1 6 Units	CAPE1 6 Units	The medical record does not support the coding of a mechanically altered diet on the MDS in Section K. A mechanically altered diet is specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. The resident has orders for a regular texture diet with thin liquids.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					This diet is recommended by the SLP. The change in coding affects the SLP case mix group.	
[redacted]	[redacted]	04/13/2020-04/30/2020	KEGD1 18 Units	IEED1 18 Units	The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, and walk 150 feet. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 20 to 0 and the nursing function score from 14 to 0.	
[redacted]	[redacted]	05/01/2020-05/27/2020	KEGD1 27 Units	IEED1 22 Units	The Subject Facility reported a payment of $21,558.85 for this claim. The calculated amount that should have been paid is $14,096.70. The Subject Facility notified WPS on 9/18/2020. WPS instructed the facility to adjust the claim mid-October 2020. The	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					excess payment received in error is recorded as an Overpayment. This patient tested positive for COVID-19 on 4/10/2020 and exhibited mild to moderate symptoms. Observation and assessment were appropriate and supported by documentation through 5/12/2020. The physician documents on 5/12/2020 that the resident is "back to pre-COVID baseline". Therapy ended on 5/22/2020. As of 5/22/2020, the patient is not considered infectious and has not presented with a worsening medical condition. The documentation does not support that the patient required daily skilled nursing services after the therapy discharged on 5/22/2020. The last covered day for Medicare is 5/22/2020.	
[redacted]	[redacted]	04/01/2020-04/21/2020	JFED1 9 Units KDCC0 11 Units	JFED1 9 Units IDMD0 11 Units	The documentation does not support the criteria for coding isolation on the IPA MDS with ARD 4/10/2020. The RAI manual instructs to code for “single room isolation” only when all of the following conditions are met:	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.). The resident uses a power wheelchair and the ADL flow sheet covering the lookback	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					period had entries of total dependence and independent self performance, and one person physical assist or no setup support for locomotion on unit (how the Resident moves between locations in his room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair); and entries of independent self-performance, and no setup or setup help only support for locomotion off unit (how the Resident moves to and returns from off-unit locations). The Social Service note dated 4/9/2020 indicated, "SSD stopped in resident's room to discuss the incident that happened in the morning. Resident was not in his room. SS will continue to provide support and remain avail PRN.", which indicates resident was not treated in room. The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed and toilet transfer. The medical record does not contain	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					sufficient nursing documentation or specific therapy documentation to support coding of the listed tasks; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 10 to 0 and the nursing function score from 6 to 0. The Resident tested positive for COVID-19, and the IPA MDS with an ARD of 4/10/2020 had a reported primary diagnosis of B97.29-Other coronavirus as the cause of diseases classified elsewhere. According to the ICD-10-CM Official Coding and Reporting Guidelines, Chapter 1, Certain Infectious and Parasitic Diseases, the appropriate code would be U07.1-2019-nCoV acute respiratory disease for positive COVID-19 cases from 4/1/2020-9/30/2020. ICD-10 B97.29 is used for positive COVID-19 residents from 2/20/2020-3/31/2020.	
[redacted]	[redacted]	05/01/2020-05/31/2020	KDPD1 31 Units	KDPD1 22 Units	The Medicare Benefit Policy Manual, Chapter 8, Section 30 identifies four factors that must	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					be met for SNF care to be covered. These factors are: • The patient requires skilled nursing services or skilled rehabilitation services, that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services; • The patient requires these skilled services on a daily basis; • As a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF; and Daily skilled services are documented through 5/22/2020. Beginning 5/23/2020, the documentation does not support that the resident required daily	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					skilled nursing and rehabilitation services. PT discharged the resident on 5/22/2020 and OT discharged the resident on 5/20/2020. The resident was referred back to OT due to left shoulder subluxation with a start of care date 5/26/2020 and the plan of care, signed by the physician, indicated treatment frequency of three times per week. There is no documented skilled nursing care after the 5/22/2020 PT discharge. The physician notes on 5/21/2020 do not support the need for continuing skilled nursing care. The physician note indicates signs and symptoms for COVID should be monitored. However, observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized. As of 5/21/2020, this patient was	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					stabilized. The documentation does not support that the patient required daily skilled nursing services and therapy is considered daily skilled if delivered five days per week. The last covered day for Medicare Part A is 5/22/2020.	
[redacted]	[redacted]	06/01/2020-06/05/2020	KDPD1 5 Units	KDPD1 0 Units	The Medicare Benefit Policy Manual, Chapter 8, Section 30 identifies four factors that must be met for SNF care to be covered. These factors are: • The patient requires skilled nursing services or skilled rehabilitation services, that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					• The patient requires these skilled services on a daily basis; • As a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF; and Daily skilled services are documented through 5/22/2020. Beginning 5/23/2020, the documentation does not support that the resident required daily skilled nursing and rehabilitation services. PT discharged the resident on 5/22/2020 and OT discharged the resident on 5/20/2020. The resident was referred back to OT due to left shoulder subluxation with a start of care date 5/26/2020 and the plan of care, signed by the physician, indicated treatment frequency of three times per week. There is no documented skilled nursing care after the 5/22/2020 PT discharge. The physician notes on 5/21/2020 do not support the need for continuing skilled nursing care. The physician note indicates signs and symptoms for COVID should	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					be monitored. However, observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized. As of 5/21/2020, this patient was stabilized. The documentation does not support that the patient required daily skilled nursing services and therapy is considered daily skilled if delivered five days per week. The last covered day for Medicare Part A is 5/22/2020.	
[redacted]	[redacted]	11/02/2019-11/15/2019	JGEE1 14 Units	JDEE1 14 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
[redacted]	[redacted]	03/09/2020-03/31/2020	JGMF1 17 Units JGCE0 6 Units	IDMF1 17 Units IDCE0 6 Units	The CMS benefit period waiver allows for additional Medicare coverage for beneficiaries who have begun but could not complete the 60-day break in the spell of illness. Medicare coverage for this resident was allowed under the CMS benefit waiver. The Subject Facility billed this Patient Stay as a continuation of the prior stay and not a new Medicare Patient Stay. As a result, the payment received by the Subject Facility is not accurate. The Subject Facility is in the process of correcting this claim. For the audit, LWCI will record the actual payment received as of the end of the Reporting Period. The audited payment will reflect the amount that should be paid following the rules set forth by CMS. On the 5-Day MDS with ARD3/16/2020, the documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, and toilet transfer. The medical record does not contain	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					sufficient nursing documentation or specific therapy documentation to support coding and the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 8 to 0 and the nursing function score from 4 to 0. On the IPA MDS with ARD 3/26/2020, the documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, and toilet transfer. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding and the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 7 to 0 and the nursing function score from 5 to 0. The resident interview for assessment of cognition in Section C on the 5-Day MDS and the IPA was completed after the ARD, based on the signature in	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	
[redacted]	[redacted]	04/01/2020-04/26/2020	JGCE0 26 Units	IDCE0 26 Units	The CMS benefit period waiver allows for additional Medicare coverage for beneficiaries who have begun but could not complete the 60-day break in the spell of illness. Medicare coverage for this resident was allowed under the CMS benefit waiver. The Subject Facility billed this Patient Stay as a continuation of the prior stay and not a new Medicare Patient Stay. As a result, the payment received by the Subject Facility is not accurate. The Subject Facility is in the process of correcting this claim. For the audit, LWCI will record the actual payment received as of the end of the Reporting Period. The audited payment will reflect the amount that should be paid following the rules set forth by CMS. On the IPA MDS with ARD 3/26/2020, the documentation in the medical record does not	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, and toilet transfer. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding and the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 7 to 0 and the nursing function score from 5 to 0. The resident interview for assessment of cognition in Section C on the IPA was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	
[redacted]	[redacted]	03/01/2020-03/19/2020	NLMF1 19 Units	NLMF1 6 Units	The Medicare Benefit Policy Manual, Chapter 8, Section 30 identifies four factors that must be met for SNF care to be covered. These factors are: • The patient requires skilled nursing services or skilled	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					rehabilitation services, that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services; • The patient requires these skilled services on a daily basis; • As a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF; and Daily skilled services are documented through 3/6/2020. The Nurse Practitioner's discharge summary is written on 3/6/2020. The note cites that the patient is refusing care, lacks progress and the family requests limited care; the documentation does not support that the resident required daily skilled	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					nursing care and rehabilitation services are discontinued. As of 3/7/2020, this patient no longer meets the requirement for daily skilled care. The documentation does not support that the patient required daily skilled nursing services. The resident is discharged from PT on 3/5/2020, discharged from OT on 3/6/2020, and discharged from SLP on 2/18/2020. The nursing documentation 3/7/2020 - 3/19/2020 does not demonstrate skilled nursing care was provided. Routine nursing care which included medication administration, assistance with activities of daily living, monitoring vital signs and monitoring for pain was provided 3/7/2020 - 3/19/2020 without the intent for change. Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures,	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					until the patient's condition is essentially stabilized. As of 3/6/2020, this patient was stabilized. The last covered day for Medicare Part A is 3/6/2020.	
[redacted]	[redacted]	06/19/2020-06/30/2020	GFPE1 12 Units	GCPE1 12 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	
[redacted]	[redacted]	07/01/2020-07/28/2020	GFPE1 27 Units	GCPE1 13 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group. The therapy documentation was not submitted for this resident. The PT, OT, and SLP documentation in the medical record is for another resident. According to the SNF	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					certification, skilled services are needed for PT, OT, SLP, pain management, cardiovascular management, respiratory care, behavior management, teaching and training. Without supporting therapy documentation, the auditor is unable to support SNF skilled care for rehabilitation for the entire stay. The Medicare Benefit Policy Manual, Chapter 8, Section 30 identifies four factors that must be met for SNF care to be covered. These factors are: • The patient requires skilled nursing services or skilled rehabilitation services, that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					• The patient requires these skilled services on a daily basis; • As a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF; and Daily skilled services are documented through 7/13/2020. Beginning 7/14/2020, the documentation does not support that the resident required daily skilled nursing services. As of 7/14/2020, the oxygen saturation levels are stable on room air, the laceration to the forehead is resolved, there are no signs or symptoms of infection to the chin, and she is stable on her medications, single room contact isolation is discontinued since she has no symptoms and the COVID-19 test is negative. The physician notes do not support the need for skilled nursing care in this claim month after 7/13/2020. The physician note indicates staff should monitor behaviors and effectiveness of psych meds; however observation and assessment are skilled services	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized. As of 7/13/2020, this patient was stabilized for nursing. The last covered day for Medicare Part A, based on the lack of therapy documentation, is 7/13/2020.	
[redacted]	[redacted]	01/02/2020-01/31/2020	OJPF1 30 Units	OGPF1 30 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The OTR completed the BIMS on 1/3/2020 with a score of 15. The change in the BIMS score impacts the SLP case mix group.	
[redacted]	[redacted]	02/01/2020-02/29/2020	OJPF1 29 Units	OGPF1 29 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The OTR completed the BIMS on 1/3/2020 with a score of 15. The change in the	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					BIMS score impacts the SLP case mix group.	
[redacted]	[redacted]	03/01/2020-03/31/2020	OJPF1 31 Units	OGPF1 31 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The OTR completed the BIMS on 1/3/2020 with a score of 15. The change in the BIMS score impacts the SLP case mix group.	
[redacted]	[redacted]	04/01/2020-04/10/2020	OJPF1 10 Units	OGPF1 10 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The OTR completed the BIMS on 1/3/2020 with a score of 15. The change in the BIMS score impacts the SLP case mix group.	
[redacted]	[redacted]	12/16/2019-12/31/2019	KAGD1 16 Units	JAGD1 16 Units	The documentation in the medical record does not support the coding in Section GG for oral hygiene, toileting, and sit to lying. Based on the documentation the proper coding for the usual performance of the functional abilities is supervision for oral hygiene, dependent for toileting, and substantial maximal for sit to lying. The corrected coding	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					changes the PT and OT function score from 11 to 9 and the nursing function score from 7 to 6.	
[redacted]	[redacted]	01/01/2020-01/03/2020	KAGD1 2 Units	JAGD1 2 Units	The documentation in the medical record does not support the coding in Section GG for oral hygiene, toileting, and sit to lying. Based on the documentation the proper coding for the usual performance of the functional abilities is supervision for oral hygiene, dependent for toileting, and substantial maximal for sit to lying. The corrected coding changes the PT and OT function score from 11 to 9 and the nursing function score from 7 to 6.	
[redacted]	[redacted]	03/19/2020-03/31/2020	KBGC1 13 Units	KCQC1 13 Units	The documentation in the medical record does not support the coding in Section GG for eating, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. Based on the documentation the proper coding for the usual performance of the functional abilities is independent for eating, sit to lying, lying to sitting	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					on side of bed, sit to stand, chair/bed-to-chair transfer and toilet transfer, and supervision for toileting. The corrected coding changes the PT and OT function score from 12 to 17 and the nursing function score from 10 to 15. The medical record supports the coding of complaint of difficulty or pain with swallowing on the MDS in Section K. The Registered Dietician assessment dated 3/25/2020 indicated swallowing difficulty. This affects the SLP case mix group.	
[redacted]	[redacted]	04/01/2020-04/18/2020	KBGC1 18 Units	KCQC1 18 Units	The documentation in the medical record does not support the coding in Section GG for eating, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. Based on the documentation the proper coding for the usual performance of the functional abilities is independent for eating, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer and toilet transfer, and supervision	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					for toileting. The corrected coding changes the PT and OT function score from 12 to 17 and the nursing function score from 10 to 15. The medical record supports the coding of complaint of difficulty or pain with swallowing on the MDS in Section K. The Registered Dietician assessment dated 3/25/2020 indicated swallowing difficulty. This affects the SLP case mix group.	
[redacted]	[redacted]	03/20/2020-03/31/2020	KAQE1 12 Units	KAYF1 12 Units	The documentation does not support the criteria for coding isolation on the MDS. The RAI manual instructs to code for "single room isolation" only when all of the following conditions are met: 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. That is, transmission-based precautions	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					(contact, droplet, and/or airborne) must be in effect. 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.). The ADL flow sheet covering the look-back period had extensive assistance self-performance and one person physical assist support for locomotion on unit (how the resident moves between locations in her room and adjacent corridor on same floor; if in wheelchair; self-sufficiency once in chair), which indicates resident was not treated in room.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
[redacted]	[redacted]	04/01/2020-04/27/2020	KAQE1 27 Units	KAYF1 27 Units	The documentation does not support the criteria for coding isolation on the MDS. The RAI manual instructs to code for "single room isolation" only when all of the following conditions are met: 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.). The ADL flow sheet covering the look-back period had extensive assistance self-performance and one person physical assist support for locomotion on unit (how the resident moves between locations in her room and adjacent corridor on same floor; if in wheelchair; self-sufficiency once in chair), which indicates resident was not treated in room.	
[redacted]	[redacted]	10/01/2019-10/25/2019	JGPF0 23 Units	JDPF0 23 Units	The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	
[redacted]	[redacted]	03/08/2020-03/31/2020	KGPE1 24 Units	IDME1 24 Units	The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, walk 150 feet. Based on the documentation the proper coding for the usual performance of the functional abilities is a dash, based on no available documentation during the first three days of admission, for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 14 to 0 and the nursing function score from 10 to 0. The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					is scored 15 as normal cognition and affects the SLP case mix.	
[redacted]	[redacted]	04/01/2020-04/30/2020	KGPE1 30 Units	IDME1 30 Units	The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, walk 150 feet. Based on the documentation the proper coding for the usual performance of the functional abilities is a dash, based on no available documentation during the first three days of admission, for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. The medical record does not contain sufficient nursing documentation or specific therapy documentation to support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 14 to 0 and the nursing function score from 10 to 0.	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	
[redacted]	[redacted]	05/01/2020-05/15/2020	KGPE1 15 Units	IDME1 15 Units	The documentation in the medical record does not support the coding in Section GG for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet, walk 150 feet. Based on the documentation the proper coding for the usual performance of the functional abilities is a dash, based on no available documentation during the first three days of admission, for eating, oral hygiene, toileting, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. The medical record does not contain sufficient nursing documentation or specific therapy documentation to	

[redacted]

Sample No.	Subject Facility	Claim Date	Billed RUG	Audited RUG	Reason	[redacted]
					support coding; therefore, the MDS is coded as missing information. The corrected coding changes the PT and OT function score from 14 to 0 and the nursing function score from 10 to 0. The resident interview for assessment of cognition in Section C was completed after the ARD, based on the signature in Section Z. The proper coding for C0200-C0400 is dash (-) indicating no response. The BIMS is scored 15 as normal cognition and impacts the SLP case mix group.	

[redacted]