



# LNHA Winter Meeting

## Trends in Audits and Census Reporting

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January 18, 2013

- Introduction
- Audit Update
- Census Records
- Residents' Personal Funds Accounts
- Cost Reporting
- Appeals process
- Questions

- Fieldwork for all NH audits is complete for FY 11
- Provider improvements
  - Census
    - Improved monthly census documents
    - Better supporting documentation record retention

- Recent enhancements to cost report audit process
  - Modification of the Louisiana Medicaid cost report for home offices
  - Reduction in the number of attachments required to be submitted with the as-filed CR
  - Revision of notification letters to be more provider-specific
  - Consolidation of related findings

- Purpose of Census

- Allow for accurate accumulation of census days for cost report purposes
- Documentation to support billing

- Census rules

- Louisiana Standards for Payment for Nursing Facilities (SFP)
- Long-Term Care Provider Training Fall 2007 - [http://www.lamedicaid.com/provweb1/ProviderTraining/packets/2007ProviderTrainingMaterials/20071024\\_20LTC\\_20Provider\\_20Training.pdf](http://www.lamedicaid.com/provweb1/ProviderTraining/packets/2007ProviderTrainingMaterials/20071024_20LTC_20Provider_20Training.pdf)

- Monthly census reports – Inadequate summarization
  - Should have totals by resident for each type of day
    - In-house
      - By payor type
        - Medicare
        - Medicaid
        - Private/Other
        - Insurance
        - Hospice
      - Allowable leave day (Medicaid only – Hospital & home leaves)
      - Paid Bed Hold (Non-Medicaid & excess Medicaid leave days)
    - Should have totals for each type of day for each month
      - Sum of monthly totals should reconcile to cost report

- Monthly census reports– Inadequate or incomplete codes
  - Should have a census code for all possible occurrences
    - Admissions
    - Discharges
    - Deaths
    - Present
    - Transfers to other payor type within facility
    - Hospital leaves
    - Home leaves

- Monthly census reports– Inadequate or incomplete codes (cont'd)
  - Hospital Leave
    - Medicaid
      - First 7 days per occurrence are Allowable Leave Days
      - If resident is not discharged after Medicaid days are used:
        - Additional hospital days should be coded as either Paid or Unpaid Bed Hold Days
    - Other payors
      - If paid, code as paid bed hold
      - If unpaid, code as unpaid bed hold

- Monthly census reports– Inadequate or incomplete codes (cont'd)
  - Home leave
    - Medicaid
      - First 15 days used in a calendar year are Allowable Leave Days
      - Additional home days should be coded as either Paid or Unpaid Bed Hold
    - Other payors
      - If paid, code as paid bed hold
      - If unpaid, code as unpaid bed hold

- Census documents – Inadequate or incomplete supporting documentation
  - Home and Hospital leaves
    - Times missing from log/leave slips/nurses' notes
    - Dates per provider's supporting documentation don't agree to dates per monthly census report

- Census Improvement Suggestions
  - Develop detailed written policies that reflect DHH census regulations
  - Revise census document/software to reflect required codes and totals
  - Use written policies for training new staff and for regular updates for all nursing staff
  - Develop standard forms for documenting census occurrences
  - Perform periodic “internal audits” of supporting documentation

- Objective of RPFA rules
  - Protect residents' funds
  - Protect provider
  - Protect provider's employees
- Resident Fund rules
  - Louisiana Standards for Payment for Nursing Facilities (SFP)
  - CFR 42 Sec 483.10(c) - [www.ecfr.gov](http://www.ecfr.gov) Select title 42, section 482-599, section 483, section 483.10
  - CMS State Operations Manual Appendix PP – Guidance to Surveyors for Long-term Care Facilities - [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)

- Common RPFA findings
  - Eligibility – Balances over \$2000
    - Income limit - \$2000 in any month
    - Resource limit - \$2000 at 12:01am on 1st day of each month
  - RPFA bank accounts
    - No reconciliations
    - Unresolved bank reconciliation differences
    - Old outstanding checks
    - Other reconciling items not resolved timely
    - Non-interest bearing accounts

- Common RPFA findings
  - Inadequate surety bond
    - Should cover the highest balance each month
  - Inadequate policies and procedures
    - Should cover all items in Chapter 8 of the NH Standards for Payment (SFP)
    - Should be specific to each provider

- RPFAs Improvement Suggestions
  - Develop detailed written policies and procedures that are specific to your facility
  - Staff training and frequent staff refreshers
  - Develop standard forms/templates for reconciliations, vouchers, family or resident requests
  - Increase administrative oversight

- Objective of cost reports
  - Provide data used for future rate setting
  - Direct care & care related cost settlement
  - Provide wage and other cost information for Medicare statistical use
- Cost report rules
  - Louisiana Medicaid cost report form and instructions - <http://la.mslc.com/downloads.aspx>
  - Correspondence from DHH -Supplemental Payments Section/ Rate and Audit Unit - <http://www.dhh.louisiana.gov/index.cfm/newsroom/detail/1574>
  - Medicare Provider Reimbursement Manual (PRM or HIM-15) - [www.cms.hhs.gov/Manuals/PBM/list.asp](http://www.cms.hhs.gov/Manuals/PBM/list.asp)
    - Click on Pub 15-1

- Property tax and property insurance cost report attachments
  - Should be complete and accurate when submitted to M&S as a part the as-filed cost report
  - Schedule F-4 of the Louisiana Medicaid cost report can be used to aid provider in determining if all invoices are attached
    - Alternate schedules can be used, but should include all of the same information as Sch. F-4
  - Unsupported amounts or amounts the do not reconcile to the cost report will be adjusted
    - No change in DHH current policy
  - The process of emailing and calling to request missing documents will be discontinued
    - Documentation will be evaluated based information submitted with as-filed CR

- Statistics – Worksheet B-1
  - Nonreimbursable cost centers
    - Leased space
    - Unused space
    - Space used for other related businesses (pharmacy, therapy, etc.)
    - Physician office
    - Gift shop
  - Square feet, meals, pounds of laundry, etc. must be kept related to nonreimbursable cost center and reported on Medicare cost report

- Suggestions for Improvements
  - Send year-end cost report information to your cost report preparer early
    - Should be organized and complete
    - Respond timely and thoroughly to questions
    - Request a checklist/use the checklist provided by your preparer
  - Consider revising the general ledger to better capture:
    - Non-allowable costs
    - Costs needed for disclosure items
      - Related party costs
      - Pass-through costs

- Suggestions for Improvements
  - Train accounts payable staff to use new GL accounts to code invoices properly throughout the year
  - Review prior years' desk review/audit findings and adjustments with staff or consultant when received and before filing current year cost report
  - Before signing cost report for current year, review the cost report and all attachments for completeness

- Appeals are provider's opportunities to dispute findings by DHH or our Contractors.
- There are two appeal processes for Nursing Home Providers to dispute desk review / audit findings
  - Informal Reviews
  - Administrative Appeals

- Informal Reviews
  - Conducted by Rate and Audit Review (RAR) Staff
  - In person or via telephone
  - Generally does not involve attorneys
  
- Administrative Appeals
  - Conducted by Administrative Law Judge
  - In person or via telephone
  - Generally does involve attorneys

- Timelines

- Upon notice of Desk Review / Audit Findings provider has 30 calendar days to file for either an informal review or a administrative appeal.
- If neither is filed, all appeal rights are exhausted. Desk Review / Audit Findings are Final.
- If informal review is requested, rate and audit will schedule the hearing.
- After the hearing RAR will send Notice of Results.
- Upon Notice of Results provider has 30 calendar days to file an Administrative Appeal.

- Timelines (continued)
  - If no Administrative Appeal is filed, all appeal rights are exhausted. RAR decision is final.
  - If Administrative Appeal is requested, the Division of Administrative Law (DAL) will arrange for the hearing.
  - After the hearing DAL will send Notice of Results.
  - Upon Notice of Results of Administrative Appeal provider has 30 calendar days to file suit with District Court.
  - If nothing is filed all appeal rights are exhausted.

- Timelines (continued)
  - Providers may choose to forego the Informal Review and instead request an Administrative Appeal of this action directly.

- **Informal Reviews**

- You must make your request for an Informal Review in writing and within thirty (30) calendar days (including Saturdays and Sundays) of receipt of this notice. Your written request should be sent to:

Department of Health and Hospitals  
Rate & Audit Unit  
ATTN: Randy Davidson  
Medicaid Program Manager  
P. O. Box 91030  
Baton Rouge, LA 70821-9030

- **Informal Appeals** (continued)
- **Documentation must be made of the issues you wish reviewed, remedies you are requesting and regulations/statutes you are citing as precedence.**
- If you choose to include accounting (CPA) or legal consultants for this review, you must file a written notice of representation identifying him/her by name, address, and telephone number at the address given above in order that the Department may share information with them.

- Informal Reviews (continued)
  - Informal Procedures
    - No judge
    - Not recorded
    - No transcript
    - Straightforward conversation between DHH staff and provider representatives
  - Issues not listed in request for Informal Hearing will not be discussed.

- **Informal Reviews** (continued)
  - All supporting documentation **MUST** be provided to DHH before the hearing.
  - New documentation will not be considered during the hearing.
  - Issues not listed in request for Informal Hearing will not be discussed.
  - Continued request to delay the hearing will not be granted.

- Administrative Appeals

- Request for an Administrative Appeal must be sent to the address given below. Please send a copy of this request to the Rate & Audit Unit.

Division of Administrative Law – HH Section  
P.O. Box 4189  
Baton Rouge, LA 70821-4189  
(225) 342-0443

- Administrative Appeals
  - Formal procedures
    - Conducted by Administrative Law Judge
    - Recorded
    - Attorney's present the cases
    - Witnesses take an oath

- Summary
- Questions
- Thanks!

# Appendix

- Affirmative census
  - Should be performed and documented daily
  - Should be maintained by payor type
    - Also by level of care if Specialized services such as TDC, ID or NRTP are provided
  - Should identify all occurrences (admissions, discharges, leaves) and paid bed hold days
  - Should include totals by resident and by month
- Date and time of each leave should be recorded in census records or related supporting documentation (i.e., furlough sheet, leave log, etc.)
- Payment is made for day of admission and day of death
- No payment is made for day of discharge

- 7 hospital leave days per hospitalization are allowed
- 15 home leave days per calendar year are allowed
- Leave limits should be monitored by facility to ensure appropriate reporting on census and billing documents

- First day of absence is the day on which the first 24 hour period of absence expires
- Only 24 continuous hours or more is considered an absence
- The resident must be in the home for 24 hours for a leave to end. Otherwise, the leave continues
- Family/resident may pay for leave days over the limits (Paid Bed Hold Day)

# Residents' Personal Funds Account

- Basic information re: fund requirements is included in SFP Sections 8-7 through 8-12
- Detailed written policies and procedures are required
  - For protection of resident funds
- Documentation must be maintained regarding responsibility for residents' funds (ie, facility or resident/relative/other)
- Service charges for a bank account can NOT be charged to the resident account
  - Including check printing charges
  - Must be reimbursed on a timely basis

- Detail documentation must be kept for all transactions
- Deposits
  - Date
  - Source
  - Amount
- Withdrawals
  - Date
  - Payee (if check)
  - Purpose
  - Amount
- Checks should not be made payable to "Cash" or employees of the facility

# Residents' Personal Funds Account

- Deposits

- Receipts for all cash received for each resident
- Copies of all checks received for each resident
- Cash receipts journal should be maintained

- Withdrawals

- Invoice and cancelled check
- Signed voucher
- Resident choice documentation if purchase of item facility would normally pay for
- Withdrawals should not be allowed if the resident has inadequate funds for the requested purchase. Facility may fund these residents' disbursements by maintaining their vouchers in the PC fund until funds are received to pay for them.

# Residents' Personal Funds Account

- Bank account(s) must be reconciled each month to the (sum of) the ledger sheets
- Reconciliation should be reviewed and approved by someone other than the preparer or custodian of the account
- Outstanding checks that don't clear the bank within a reasonable time should be reposted to resident account and, if possible, re-issued
- Residents' funds account shall not include any facility funds

## Residents' Personal Funds Account

- If petty cash is established properly, you should not need to add petty cash to the reconciled bank balance to equal the sum of the ledger card balances
- Account name on bank account should clearly indicate that the funds are those of the facility's clients

# Residents' Personal Funds Account

- Inappropriate charges to resident fund
  - Personal hygiene items
  - Wheelchairs and other support items and medical supplies
  - Tips, gifts, expenses for staff
  - OTC drugs
  - Incontinent supplies
- Residents must receive quarterly statements

# Residents' Personal Funds Account

- Amounts in excess of \$50 with respect to a resident must be maintained in an interest bearing account
- Interest must be distributed to each resident participating in the account on an:
  - Actual interest earned basis
  - End of quarter balance basis
- Surety bond for Residents' Personal Funds Account is required
  - Should be sufficient to cover highest daily balance in account
  - Must have DHH approval if some other form of financial assurance is maintained in lieu of surety bond (i.e., letter of credit, pledged CD)

## Residents' Personal Funds Account

- Petty cash must be maintained on an imprest system
  - Facility should establish fund with facility funds
  - Replenish from residents' account
- Pre-numbered vouchers signed by resident or two witnesses
- Checks to replenish account should be made to "Custodian of Petty Cash"

## Residents' Personal Funds Account

- Funds belonging to a discharged resident must be refunded to resident or responsible party by the end of the month following the month of discharge
- See SFP section 8-11 for return upon death
- Funds that can not be returned should be maintained in residents' account and ledger sheet should be maintained in the former resident's name. After state statutory period, these funds should be returned to the State Department of Revenue (See SFP page 8-11)

- Issue: Check written to resident with no receipts
  - Use petty cash for small disbursements (\$50 or less)
    - Signed vouchers do not require receipts
  - Write checks to vendors for large disbursements (over \$50)
    - Staff accompanying resident could write in final amount and return with receipt