A Clinical Due Diligence Framework for Skilled Nursing Investment Decisions

Conventional financials go blind at the chart level. A trailing P&L can look stable while the underlying documentation is quietly overstating — or understating — what a building is worth. For capital providers evaluating distressed skilled nursing, that blind spot is exactly where price gets set wrong.

This framework outlines how to underwrite from the chart before the market sets the narrative for you.

Why Chart-Level Diligence Comes Before the Model

Standard financial due diligence answers whether the numbers on the page are internally consistent. It does not answer whether the revenue behind those numbers is defensible. In skilled nursing, reimbursement is driven by clinical documentation — MDS assessments, PDPM/HIPPS coding, physician certifications — long before it ever becomes a line item on a P&L.

That means two buildings with identical trailing financials can carry very different risk profiles. One may have revenue that would survive a Medicare Administrative Contractor (MAC) audit. The other may not. A financial model alone cannot tell the difference. A chart can.

Start Where an Auditor Would Start: Certification

An auditor reviewing a skilled nursing claim doesn't begin with the billed code. They begin with the physician certification and recertification supporting the stay. If certification is missing, late, or doesn't clearly support the level of care billed, everything downstream — MDS coding, HIPPS calculation, the claim itself — is exposed, regardless of how complete the clinical notes otherwise look.

Diligence question: Do certifications across the sampled charts consistently support the level of care billed, or is this a pattern of generic, boilerplate language that wouldn't hold up under review?

Identify the ADR/TPE Exposure Pattern

Isolated documentation gaps are a normal feature of any operation. What changes the risk calculus is repetition — the same type of gap showing up across multiple stays, which is exactly what tends to trigger an Additional Documentation Request (ADR) pattern or a Targeted Probe & Educate (TPE) review.

Diligence question: Across a representative chart sample, does a specific gap type — a diagnosis category, a therapy minute threshold, a HIPPS code — repeat often enough to constitute a pattern rather than noise?

Know the Denial Theory Before You Underwrite It

Exposure generally traces back to one of two theories: a coverage issue under Local or National Coverage Determination (LCD/NCD) rules, or a medical necessity issue — whether the clinical picture supported the level of care billed. These carry different remediation costs and different implications for revenue durability post-close.

Diligence question: For the building's highest-acuity PDPM categories, is medical necessity independently supported by the clinical narrative, separate from the MDS coding itself?

Reconcile the Note, the MDS Lock, and the Claim — For the Same Stay

This is the core mechanic of chart-level diligence, and it's where the real signal lives. For a representative sample of stays, pull three things together: the supporting clinical note, the locked MDS assessment, and the claim that was billed. Contradictions between the clinical narrative and the billed codes — or missing support for the PDPM/HIPPS drivers that justified the reimbursement level — are what should move a price or a commit/pass decision.

Diligence question: Would the billed HIPPS code make sense to someone who had only read the clinical notes, without seeing the MDS? If not, quantify how much revenue sits behind that gap, and whether it's earned-but-unbilled upside or booked-but-unsupported risk.

Use Industry Context as Backdrop, Not as Evidence

Labor market data, occupancy trends, and PDPM policy headlines are useful for understanding the environment a building operates in. They say nothing about what's in that building's chart. A facility in a favorable labor market can still carry significant undisclosed exposure, and a facility under real pressure can still have clean, defensible documentation. Sector-level data should inform context, never substitute for chart-level testing.

The Four Tests Documentation Revenue Has to Pass

Before "documentation-related revenue" belongs in an underwriting model, it needs to clear four tests:

1. **Is it real?** Does the clinical record support the coded acuity level, independent of what was billed?
2. **Is it collectible?** Is there a live path to recovery, or does the exposure/upside require a level of correction that's no longer practical post-close?
3. **Is it compliant?** Would this documentation survive an ADR, a TPE cycle, or a full MAC audit as currently written?
4. **Is it material?** Does the dollar amount — upside or exposure — move price, or move the commit/pass/watch call? Not every gap is underwriting-relevant; the ones that need to be sized explicitly, not left as a narrative caveat.

A diligence file that doesn't answer these four questions in plain underwriting language hasn't finished the job, regardless of how thorough the chart review itself was.

Applying the Framework: Commit, Pass, or Watch

The output of this process should be a decision, not just a findings memo. Once the four tests are run against a representative chart sample:

- **Commit** — the documentation-related revenue clears all four tests at a level material enough to inform price, and the exposure is either minimal or explicitly priced in.
- **Pass** — the exposure is material, not correctable within a reasonable post-close timeline, and cannot be adequately priced into the deal.
- **Watch** — early findings suggest opportunity or risk, but the sample size or documentation quality doesn't yet support a confident commit or pass call; further chart review is warranted before capital moves.

The Bottom Line

A trailing P&L tells you what a building reported. It does not tell you what a building's chart would say under audit. Chart-first diligence — starting at certification, testing for ADR/TPE pattern risk, reconciling the note, the MDS lock, and the claim, and running every finding through the real/collectible/compliant/material test — is what closes that gap before the market closes it for you.

DRL Holdings underwrites distressed skilled nursing from the chart before allocating capital. If you're a receiver, lender, or owner with a building where the chart may be moving the price of the deal, send us a file.