BHO Provider Audit Training

December 1, 2011

Community Reach Center

Northglenn, CO

Today's Agenda

- **CCQC Overview**
- **Compliance 101**
- **Compliance Plan Self Assessment**
- **Medical Record Documentation**
- **BHO Claims Review Process**
- **Clubhouse and Residential Program Reviews**

Behavioral Health Organization

Contracted with a National Consultant

Development of a Compliance Plan

"Colorado Compliance and Quality Committee (CCQC)"

CCQC Structure

❖ **Steering Committee**

    ❖**Workgroups**

        ❖**Coding Manual**

        ❖**Basic Training On Required Documentation**

        ❖**High Risk Trainings**

        ❖**Compliance Program Development**

        ❖**Compliance Audit Protocol**

CCQC Steering Committee Goals

- Revisions to the Coding Manual
- Develop manual on basic documentation/training across the State
- BHO technical assistance audits
- BHOs will have a compliance program that meet federal requirements

More Information:

Colorado Behavior Healthcare Council

at cbhc.org

click on CCQC

CCQC Steering Committee Members

- Chair, Charlotte Yianakopulos-Veatch, Chief Development Officer, Spanish Peaks MHC
- Co-Chair, Robert Bremer, Executive Director, Access Behavioral Care, Colorado Access
- Erica Arnold Miller, Vice President of Quality, ValueOptions
- Rick Doucet, CEO, Community Reach
- Julie Kellaway, Administrative Director, North Range MHC
- Barb Mettler, Chief Compliance Officer, Spanish Peaks MHC
- Barb Smith, QI Director , Foothills Behavioral Health Partners
- Kari Snelson, Chief Quality and Compliance Officer, West Central MHC
- Teresa Summers, Compliance Officer, BHI
- Karen Thompson, Executive Director, Northeast Behavioral Health Partners
- Maggie Tilley, Compliance Officer, ValueOptions
- Vicki Rogers, COO, Jefferson CMH
- Mary Thornton, Consultant, MTA

Audit Procedures Workgroup
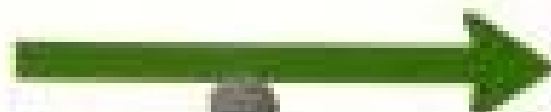
- Chair, Robert Bremer, Executive Director, Access Behavioral Care, Colorado Access
- Rhonda Borders,   , ValueOptions
- Kari Snelson, Chief Quality and Compliance Officer, West Central MHC
- Teresa Summers, Compliance Officer, BHI
- Maggie Tilley, Compliance Officer, ValueOptions
- Charlotte Yianakopulos-Veatch, Chief Development Officer, Spanish Peaks MHC

Because of our past ……. We have to be more careful to protect our future

- Partial hospital programs: 80 to 100% denial rates – 1980's and 1990's

- Rehabilitation option: West Virginia series – 70% and up denials - Abraxas: 1995

- Medicare Outpatient 2001: almost 20% of medication management , 33 % of individual therapy, up to 50% of group therapy – 2011

- Medicare Outpatient: 47% error rate – 2044

- Rehabilitation Options: Adult services 100% error rates; kids lower – Iowa 2004 & 2005

- Residential Audit: Repayment request $207M – New York

The Overall Federal Landscape

- Hundreds of millions to enforcement and oversight
  - Big emphasis on improper payments in addition to fraud
  - Quality of care – "worthless services" – concept of harm associated with non-medically necessary or poorly provided services, not just cost
  - Provider based audits as opposed to solely state based audits
    - Extrapolation by provider, rather than by state.
    - RAC and Medicaid

How Do Providers Protect Themselves?

- Demonstrate that you have the capacity to self-police.
  - Development of a compliance program
  - Routine paybacks or explained paybacks
- External audit results improving
  - Claims reviews
  - All medically necessary services – for capitated programs
  - Only medically necessary services – for fee for service
- Active and on-going training program

The Most Immediate Concerns

- Medicaid RAC - Recovery Audit Contractors paid on a contingency basis

- Medicaid Integrity Program Contractors – provider audits, not just state reviews

Major Differences from OIG and DOJ Investigators

- Not fraud focus - Improper payments
- Quality of care

This means: quality, compliance, and risk must either merge or work without silos on strategic risk based issues

The reviews being discussed today attempt to involve all three in the BHO audit protocol

Why Not Just Wait for Them to Come?

- Extrapolation
  - Paybacks for FFS
  - Reduction in rates if large numbers of encounters are disallowed
- New FERA and PPACA rules require providers to repay or reverse encounters within certain time frames – or subject to False Claims Act.

Why Do We Do So Badly on Audits?

- Documentation: not there, not complete, not timely, not meeting technical requirements.
  - 411 audits
  - BHO Claims reviews
- Content of service: not a "covered" service
  - BHO Claims reviews
- Quality of Care: services not sufficient (capitated); too many services (FFS); not meeting generally accepted standards of care
  - Medical records reviews

Aren't the 411 Audits Enough?

- Do address many of the technical requirements

- Do not address treatment plans

- Do not address content of service – more later

The BHO Claims Reviews

- Note: not audits
- Technical assistance focused: where is each provider most at risk?
- Paybacks of reversals of encounters: only errors found, not extrapolated
  - Do you have to do the paybacks and reversals?
    - yes both FERA and PPACA laws require this

The Medical Record Reviews

- Review quality of documentation
- Are all medically necessary services being provided?
- Is there a clinical strategy that makes sense and is it being implemented?
  - Golden thread
  - Reasonable and necessary services

Recent Audits: A Changing Landscape

- New York Residential Audit: focus on medical necessity of services and who can determine this.

- New York Day Treatment Audit: focus on compliance with state – NOT federal – requirements.

NY CDT Audit

- Of the 100 claims in our random sample, all claims complied with Federal requirements and 43 claims complied with Federal and State requirements, but 57 claims did not comply with State requirements.

New York CDT

- " Pursuant to State requirements for Medicaid reimbursement of CDT services, a recipient's treatment plan must: (1) be completed in a timely manner, (2) be signed and approved by the recipient, (3) include criteria for discharge planning, and (4) be reviewed every 3 months. In addition, CDT services must be adequately documented (including type and duration of services) and provided in accordance with the recipient's treatment plan."

NY CDT Results

Of the 57 noncompliant claims, 10 contained more than 1 deficiency:

- For 43 claims, the type of service was not documented.
- For eight claims, progress notes were not properly recorded.
- For seven claims, the duration of the recipient's contact with staff was not indicated.
- For three claims, the treatment plan was not completed in a timely manner.
- For three claims, the treatment plan was incomplete.
- For two claims, service hours were improperly calculated.
- For one claim, the recipient's participation in treatment planning was not documented.
- For one claim, the treatment plan was not reviewed in a timely manner.
- For one claim, CDT services were not provided.

For three claims, the treatment plan was incomplete.

- For two claims, service hours were improperly calculated.

- For one claim, the recipient's participation in treatment planning was not documented.

- For one claim, the treatment plan was not reviewed in a timely manner.

- For one claim, CDT services were not provided.

Key Errors

- Pursuant to 14 NYCRR § 588.7(d), a recipient's treatment plan shall be completed before the recipient's 12th visit after admission or within 30 days of admission, whichever occurs first.

    For 3 of the 100 claims in our sample, the recipient's treatment plan was not completed before the recipient's 12th visit after admission or within 30 days of admission.

Key Errors

- Pursuant to 14 NYCRR § 587.16(c), recipient participation in treatment planning and approval of the plan shall be documented by the recipient's signature. If a recipient cannot participate in treatment planning and/or approval of the treatment plan, reasons for the recipient's nonparticipation shall be documented in the case record.

  - For 1 of the 100 claims in our sample, the treatment plan did not contain the recipient's signature, and the case record did not document reasons for the recipient's nonparticipation.

The BHO Audit Plan

- Intent is to address key risk areas using the most current information on the types of errors found in behavioral healthcare.
  - Determination that where external reviews were most important that the BHO's would spend most resources here.
  - Determination that where providers developed robust compliance programs, the risk for the whole system was reduced.
  - Determination that where medical record quality is concerned, the BHOs needed to make sure that the BHOs and providers were in agreement as to what constitutes quality in documentation but also in service delivery.

COMPLIANCE PLAN SELF ASSESSMENT

Your Compliance Plan

- Four reasons for working towards an "effective" compliance program:
  - Office of the Inspector General – strongly suggests
  - DRA – requires for providers over $5 million
  - BHO Contract with CMHC providers: requires a compliance program
  - PPACA requires Medicaid providers to have compliance programs –no regulations yet

PPACA and Compliance

- Rule specifically laid out 8 elements for nursing homes.

- Regulations for other Medicaid providers not issued yet, however recent expansions of requirements for Medicare A and Medicare D providers show additional attention to the detail of each of the elements

The Assessment Tool

- The goal is to help you evaluate your current compliance efforts as a whole program.
  - This is not about a <u>plan</u>, it's about a complete <u>program</u>.
  - A plan is about where you will go; a program is what you have now.
- Small physician practices can still use the tool but the programs will be scaled down. See the OIG guidance

Compliance Self-Assessment Tool

The 7 Elements

1. Oversight
2. Standards and Procedures
3. Education and Training
4. Auditing and Monitoring
5. Reporting
6. Enforcement and Discipline
7. Response and Prevention

The implied 8th Element:

- Periodically reassess the compliance program and review risk

The Assessment Tool

1. Written policies and procedures
2. Designate Compliance Officer
3. Designate Compliance Committee
4. Training & Education
5. Communication
6. Disciplinary Policies
7. Identification of Compliance Risk Areas
8. System for Responding to Compliance Issues
9. Non-intimidation & Non-retaliation

How Should You Use the Tool?

- Use this tool to help you think about your program
  - What you do well, what you can improve
- The tool is not a crosswalk to the Seven Elements
- When the tool says "system" think about "processes" - both formal and informal
- Use the tool to help you evaluate your program thoroughly and do more than just check the boxes

Compliance Program Goals

- It's about creating a culture of compliance
- Documentation is critical (not just in the medical record)
- Informal processes may need to be documented
  - opportunity to improve them by showing you the gaps or areas for improvement
- Everyone understands the duty to report concerns and ask questions
- No fear of retaliation
- Help everyone be successful

Evaluating Your Program

- Give people the tools they need
  - Education
  - Direction
  - Support
- How do people know what we expect? We inform them!
  - Code of Conduct
  - Training
  - Policies and Procedures
  - Continuous Communication

Program Evaluation: Policies & Procedures

- Code of Conduct = Overview

- Policies and Procedures = What we expect and how to accomplish it.

- Embed compliance into other P&Ps (HR, Billing)

Policy vs. Procedure

- A Policy is <u>what</u> you expect people to do

- A Procedure tells someone <u>how</u> to do it

Program Evaluation: Policies & Procedures

- Are your P&Ps
  - clearly written
  - directive
  - helpful
- A policy won't be effective if someone can't easily follow the steps or understand how it impacts them

Program Evaluation: Policies & Procedures

- Do you need front office and back office policies?
  - A compliance policy outlining the requirements to abide by a regulation
  - Supportive department policies that tell people exactly how to do their job in light of the regulation
  - Example: An HR policy stating compliance issues should be reported. A back-office Compliance Department policy instructing the compliance team how to conduct the investigation. (The HR policy doesn't require the same amount of detail.)
- Policies and Procedures don't need to repeat the statute verbatim.
  - Tell people what law they are following and why
  - Use plain language to provide instruction

Other Evaluations to Consider

- Review your processes and BHO provider agreements

- What obligations must you meet? How do you meet them?

- Create a cross-walk

Compliance Expectations

- Use this tool to evaluate and improve
- Can't do everything at once so you need to identify and prioritize
- Engage in thoughtful, continuous review
- Strive for improvement
- Revise as necessary
- Ask for help

Design Your Program to Meet the Seven Elements

- Document all you do and how you do it
  - Identify your informal processes
- Designate roles & responsibilities
- Code of Conduct
- Policies & Procedures
  - Include one for each element as well as the relevant laws and regulations
- Education of employees, volunteers, Board of Directors

Design Your Program to Meet the Seven Elements

- Visibility and Communication
  - Newsletters
  - Hotline Information
  - Compliance contact information in relevant places
- Monitoring (audits, investigations, Corrective Action Plans)
- Work plans – what you will address and how

Compliance Plan Certification

- CMHCs and Providers are NOT being asked to certify that their compliance programs meet PPACA and Sentencing Guideline standards
- BHOs are likely to ask for this next year
- Point is to address areas of deficiency
- Sharing of self assessment

Online Resources

- In addition to HCPF, your BHO, CBHC, and ValueOptions, there are many sources for information and tools to build your compliance program:
  - National Council for Community Behavioral Healthcare posts prior webinars www.thenationalcouncil.org/cs/recordings_presentations
  - OIG www.oig.hhs.gov
    - Other compliance guidance, audits, and advice
    - OIG Small Practice guidance: http://oig.hhs.gov/authorities/docs/physician.pdf
  - Health Care Compliance Association ww.hcca-info.org
  - CBHC www.cbhc.org
  - Law firms
  - Other large providers post their compliance materials (such as HCA http://hcaethics.com/introduction/)

BREAK TIME

MEDICAL RECORD DOCUMENTATION

Medical Records Reviews

- Intended to ensure that providers and BHOs are in agreement as to what constitutes acceptable medical record documentation.

- Reviews require provider to score each element themselves and then to attach the documentation they used to make that determination.

- BHOs will then review your scoring and accompanying documentation and get back to you where there are discrepancies.

- BHOs will also use this information for determining training and technical assistance needs.

- Goal: you are the experts in your own documentation and the BHOs can concentrate on other risk areas.
  - You are required to do auditing and monitoring as a part of your compliance program.

The Reviews

- Are we being too picky? Federal government increasingly absorbed with details as it moves forward on "improper payments".

- So if I get a good score can I relax? No, not necessarily. It is possible to get a good score and still fail a claim.

- Then how do I figure out where my risk is? Combination of both the medical record review and the claims audit.

The Reviews

- Why so many questions? The review is intended to be a comprehensive look at both the quality of your clinical strategies and your documentation.

- How should I use the tool to evaluate the above? Look at each section's score as well as the overall score. Also look at those questions that require clinical expertise – the quality of the clinical formulation, are all necessary services being provided, etc.

General Instructions

- Self audit of 10 records randomly selected by the BHO twice annually

- Replaces BHO on-site reviews

- Must be completed by a licensed clinician

- Provide supporting documentation

- All Partially Met or Not Met elements must include comment

- Spots checks for inter-rater reliability

- Results shared among BHO CCO without PHI

Timeline

- CMHCs and providers will receive sample in May 2012

- 45 Days to complete

- Second round scheduled for Oct 2012

- BHO will provide feedback and any required corrective actions

Record Review Sections

- Section A. Administrative

- Section B. Assessment

- Section C. Treatment Plan

- Section D. Progress Notes

- Section E. Medication Management

- Section F. Coordination of Care

General Medicaid Documentation Requirements

- Assessment: in Colorado the assessment and the CCAR should be congruent with one another.
  - Key questions:
    - Presenting problem and severity of clinical picture is easy to discern.
    - The analysis of the diagnosis, Individual's commitment to treatment, and recommendations for care based on a prioritized list of needs/problems is thorough and clinically sound.

Section B. Assessment

- Nothing new about these requirements
- Partially Met – the element is there but is incomplete
- Does look to see that the CCAR is congruent with clinical assessment
- B20-BHOs requiring updated annually. The tool states q 6 mos – that is incorrect
- Questions?

Section C. Treatment Plan

- Signed within 30 days of initiating services
- Treatment plans must be signed by a licensed practitioner of the healing arts within the scope of their practice
- Refer to Nov 17 BHO memo
- C9, C10, C11 are met or not met. No partial.
- Note: C14 - updated annually

Section D. Progress Notes

- This section requires clinical experience to score

- D2 is met or not met. No partial credit.

	SECTION D: Progress Notes Requirements
D1	Services provided to client correspond to those ordered on the tx plan in type and frequency
D2	Each progress note includes date, place, time, duration, persons present, CPT/procedure code, signed by provider w/ credentials, date signed
D3	Each note refers to the goals & objectives from the current tx plan being addressed in that session
D4	Notes describe skilled clinical interventions or techniques used by provider
D5	Client's response to intervention used & progress toward goal is described in each note

	SECTION D: Progress Notes Requirements
D6	Interpretation when needed is documented in session note and provided by a non-family member
D7	Lethality/Risk assessed at each visit if indicators exist . Referral to higher level of care if indicated
D8	Substance abuse addressed as often as needed for client's presentation; or referral made to specialized treatment
D9	Evidence present of outreach to clients who miss appointments, especially if high risk (NOTE: Mark NA only if client never missed appointments.)

Section E. Medication Management

- Requires clinical experience
- E2 is met or not met. No partial credit.

Section F. Coordination of Care

- These requirements can be embed within progress notes and difficult to find
  - Means it is difficult to ensure it is being done
- F2, F3, F4 are met or not met. No partial credit.

Scoring and Certification

- X's in each cell automatically scores the tool

- Signature and credentials of person completing the audit

- Final results must be certified by the Quality Director and CEO/ED or by the contracted provider

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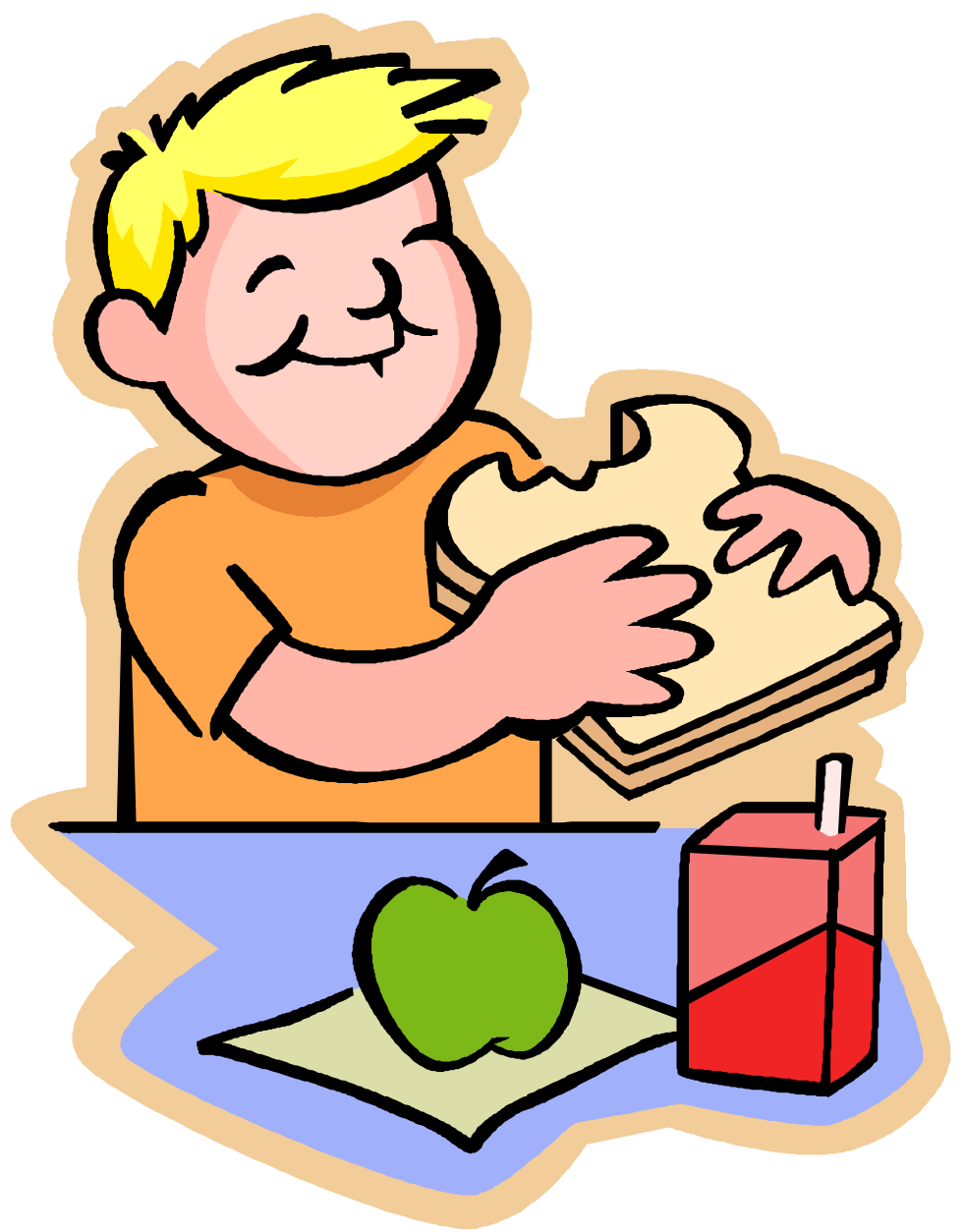
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Know What's Coming

BHO CLAIMS REVIEW PROCESS

BHO Claims Review Process

- HCPF rate setting places greater emphasis on validity of claims/encounters

- Current 411 audit does not include review of treatment plan
  - Federal audits focus on this
  - Claims aren't valid w/o the tx plan

- First year is technical assistance audit

- Hope to merge with 411 in the future

General Instructions

- 60 claims selected randomly, first 50 reviewed

- If record not available, the claim is failed with no errors

- No partial scores, 0 means no error, 1 means error or incomplete document

- Fatal errors are errors that fail the claim regardless of compliance with other questions.

- One or more fatal errors cause a claim to be reversed

General Instructions

The Tool:

- Automatically counts the types of errors
- Automatically counts the total errors
- Each worksheet accommodates 10 claims
- The Tool accommodates 50 claims

Claim Review Criteria

1. Is there a treatment plan that is current?

2. Is the treatment plan signed with credentials and date by the clinician completing the plan?

3. Is the treatment plan signed with credentials and date by the appropriately licensed practitioner of the healing arts?

4. Is the treatment plan signed by the Medicaid beneficiary or is there a progress note detailing the reasons why the plan is not signed?

5. Is there a progress note for the date of the claim reviewed?

6. Service Type is Documented and matches claim?

7. Service Date is Documented?

Claim Review Criteria

8. Number of Units Billed Matches Actual Units Billed

9. Name, Title and Credentials and date of signature of the Person Providing Service is Documented.

10. The Setting in Which the Service Was Rendered is Documented.

11. The Service Delivered is Contained in the Consumer's ISP or Treatment Plan.

12. The Progress Note describes a service that is linked to a goal in the treatment plan?

13. There is a Progress Note that corresponds to the Service Billed.

14. Diagnosis that was the focus of treatment is listed?

Scoring and Results

- Not expecting perfection. Do expect improvement between rounds 1 and 2.

- All except 9 and 14 are fatal flaws

- Invalid claims will need to be recouped – required by PPACA

- Will give us a sense of impact if a federal audit extrapolated

Claims Review Timeline

- First round of 50 claims in April-May 2012 based on claims/encounters from Feb-Mar

- Second round of 50 claims in Oct 2012

Timeline

- Compliance Plan Self Assessment – Jan 2012

- Round 1: Claims Review – Apr/May 2012

- Round 1: Record Audit – May 2012

- Round 2: Claims Review – Oct 2012

- Round 2: Record Audit – Oct 2012

Final Questions

Program Reviews

- Inpatient Services

- Clubhouse and Drop-in Programs

- Residential Treatment Programs

Clubhouse and Drop-In Center Reviews

- A review to determine how to audit
  - Anecdotal only evidence of wide variation in practice and in billing
  - Concern about two ostensibly different programs using same definition and same medical record requirements
  - No federal audit information available as to how they will review these programs
    - Likely will rely very heavily on state rules

Clubhouse and Drop-In Center Reviews

- Two parts:
  - Survey of administrative, billing, and clinical operations
  - Review of random sample of 5 claims for general Medicaid compliance
    - At this time, not using specific documentation requirements from the coding manual – survey questions get at this information

Clubhouse and Drop-In Center Reviews

- Who should be involved?
  - Program staff – daily operations, documentation requirements, treatment planning, scheduling, etc.
  - Billing staff – we need to know how information on what to bill comes from the program to billing and then how it is coded in the encounters
  - Clinical staff - assistance with review of the content of the documentation for medical necessity and clinical integrity

Clubhouse and Drop-In Center Reviews

- Why now and why so fast?
  - Audit risk : remember the recent NY audits
  - Coding Manual Committee of CCQC: we need your help!

Residential Program Review

- Very similar to the Clubhouse/Drop-In Center reviews
  - Anecdotal information suggests variation in practice and in billing?
  - Where is treatment taking place? In community or in residence?
  - Understanding of the role of Medicaid in non-PRTF residential programs.

Residential Program Review

- Review document still in draft form but in general two parts:
  - Survey of general practice
  - Review of specific claims – encountered day
- Differences from Clubhouse
  - We have more information from federal audits and federal settlements with residential programs both adult and children's programs.
  - IMD issue: are the programs with larger numbers of beds actually eligible to bill Medicaid? Colorado's children's programs were reviewed and substantially changed after federal reviews.

Residential Program Reviews

- Who should be involved?
  - Finance staff: general understanding of what role Medicaid plays in funding services
  - Program staff – daily operations, documentation requirements, treatment planning, scheduling, etc.
  - Billing staff – we need to know how information on what to bill comes from the program to billing and then how it is coded in the encounters
  - Clinical staff - assistance with review of the content of the documentation for medical necessity and clinical integrity

Residential Reviews

- Why now and why so fast?
    - Audit risk : remember the recent NY audits
    - Coding Manual Committee of CCQC: we need your help!
        - What services other than the per diem should be billable? Is residential a bigger bundle of services?