GREAT RIVERS

BEHAVIORAL HEALTH

Cowlitz Gray Harbor Lewis Pacific Wahkiakum

Auditing

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Goal:
Obtain a Better Understanding of Documentation Auditing in of Behavioral Health Services in Washington State

Workshop Description:

Audits are conducted to ensure the validity and reliability of information; also to provide an assessment of an agency's or organizations strengths, risk and areas of improvement. This session will focus on auditing tools and the roles of Behavioral Health Agencies, Behavioral Health Organizations, State and Federal Oversight Agencies.

Types of Audits

- Behavioral Health Agency – Self Audit
- Behavioral Health Organization – Contract Audit and Encounter Validation Audit
- State Licensure Audit – Compliance with Washington State Administrative Codes
- External Quality Review Audit – Review of the State Plan, use of Medicaid Service dollars.

Why Audit?

- Audits are important tools that makes use of information systems and specific indicators to assess whether particular aspects of service provision are measuring up to the established standards.

- The quality framework focuses on a whole systems approach to the provision of behavioral health services recognizing that services need to communicate and collaborate across settings and functions. Integrated throughout the framework is an emphasis on continuous quality improvement as it is believed this is key to the development of a quality behavioral health service. The quality framework provides a platform for continuous quality improvement in behavioral health services. It is essential that continuous quality improvement is built into the management and delivery of services.

Why Audit? continued

- Each service can use audit tools to measure and track compliance with the standards - where this is not happening, action plans for improvement should be developed, implemented and reviewed.

- When assessing an organization's levels of attainment of the standards, it is important to note that meeting the standards is not an end in itself, rather it is part of a process of continuous quality improvement. Thus, even when full attainment of a standard is achieved, it is important to look at ways in which continuous quality improvement initiatives can be developed and implemented.

Key Element for all Clinical Documentation Audits

- **Medical Necessity and Quality of Care Issues**

- "Social Security Act obligates health care providers to assure that services ordered for or provided to Medicaid and Medicare beneficiaries are –

  – Medically necessary
  – Of quality that meets professionally recognized standards of health care
  – Provided economically
  – Supported by evidence in the medical record"

Source: 2012 "The Health Care Compliance Professional's Manual"

Behavioral Health Agency Audits

- Auditing at the Behavioral Health Agency (BHA) Level will focus on the clinical records. There are five basic clinical record self-audit rules behavioral health agencies should use:
    1. Review the clinical documentation/medical record documentation policy for your organization. Make sure the policy covers meeting Federal and State Medicaid regulations. The policy should address what actually happens in everyday practice.
    2. Develop or use one of the available clinical record/medical record documentation audit tools. The tool should cover the documentation policy criteria and coding standards as part of the review. Check in with your BHO or MCOs to review what their standards are and enhance those elements to meet your Behavioral Health Agency needs.
    3. Identify an individual who understands documentation and coding principles to select a random sample of records for a specific time period. Decide how many records should be reviewed, and then pull records based on your sampling to you sample metrics.
        3.1 Determine date range for audit
        3.2 Identify a random selection process (Consider the RAT-STATS system to choose a sample using the government's sampling methodology. Go to the Office of Inspector General's Web site *http://oig.hhs.gov/* for more information on RAT-STATS)
        3.3. Ensure all services types provided by BHA are represented (SUD Outpatient, SUD Intensive Outpatient, SUD residential, MH Outpatient, specialty programs)
    4. Identify the audit team, it is important to note that auditors should not review their own records. Include management, psychiatrist and billing personal in the audit process.
    5. Ensure that you conduct an interrater reliability testing on the tool or have interpretative guidelines.
    6. Review and analyze the audit findings. Identify the common documentation, coding and billing problems, and strengths and address the problems found. Include Quality Management monitoring tools to review for improvement in performance.
    7. Utilize results to provide education to clinical staff members and hold them accountable for making changes.
    8. After implementing any corrective action plan, audit the process again to ensure improved compliance and successful implementation.
    9. Celebrate your success!

Behavioral Health Organization: Great Rivers Clinical Documentation Audit Process

- Encounter Data Validation Audit
- Annual Clinical Record/Chart Audit Tool

Presented by Lexa Donnelly, LISW
Great Rivers BHO

Encounter Data Validation

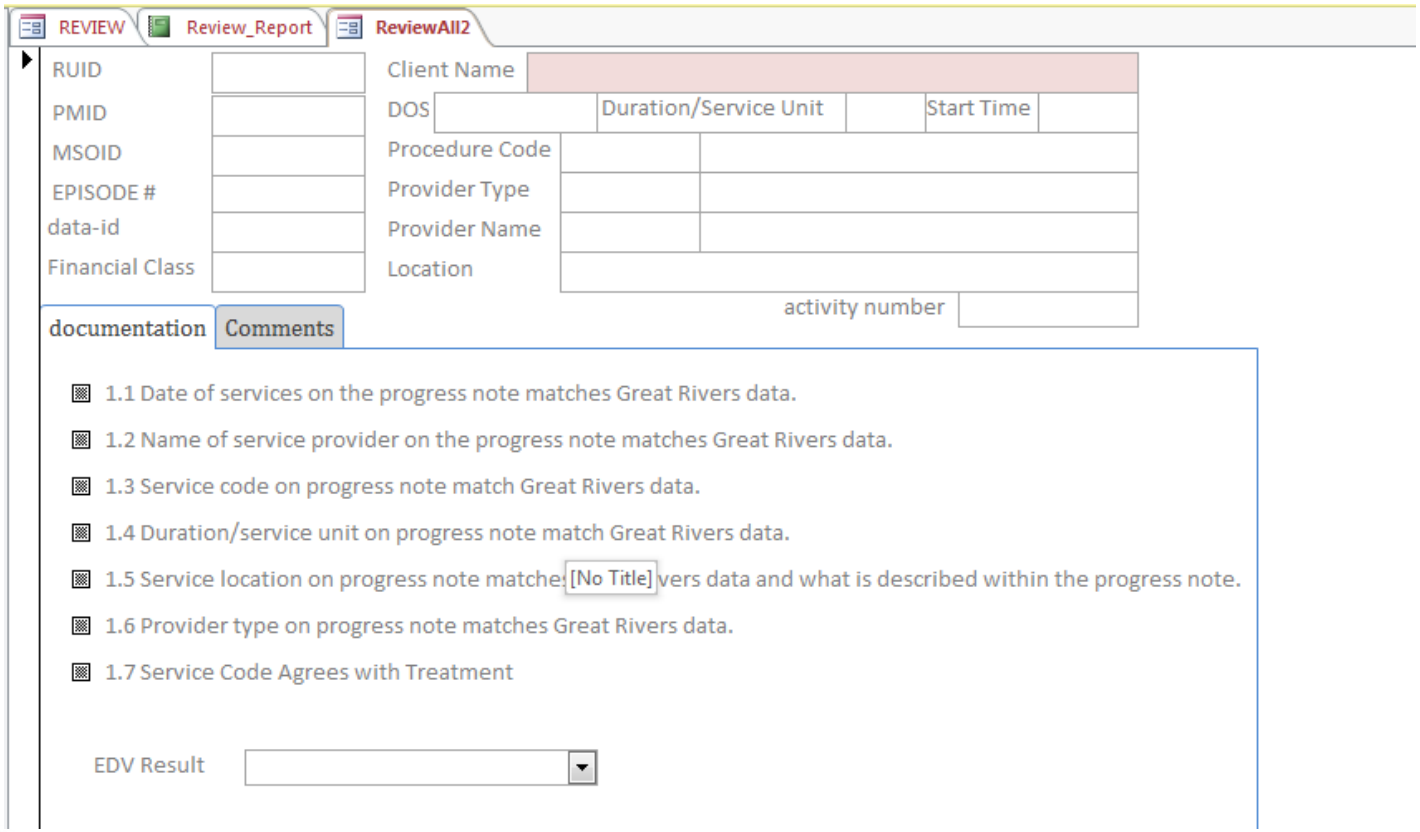
- Great Rivers conducts an EDV annually to ensure complete and accurate data are submitted to DBHR, per contract and federal regulations.

- Great Rivers' Masters-level quality management staff perform the reviews, entering the scores into the Encounter Review Access Database. This audit is conducted during our annual BHA audit.

- Two scoring criteria are used to verify the clinical records:
  - Match – exact match of all the data elements
  - No Match – Erroneous or Unsubstantiated

Encounter Data Validation

Access Database



Clinical Chart Review

- Great Rivers QM Audit Tool includes items that rely on review of a sample of each BHA's clinical records.
- Items are scored based on elements required in the relevant RCWs, WACs, CFR, contracts, and policies and procedures.
- Great Rivers created "Interpretive Guidelines" to provide clarification of the specific review criteria that will be used to score the items.
- Items are scored
  - Met
  - Not met
  - Not Applicable

Clinical Chart Review: Assessment

- Great Rivers Assessment Tool has a total of 29 unique items
  - 12 General, 2 Mental health, 6 SUD Youth, & 9 SUD items

Section Titles	Brief Description	Citation	Interpretive Guidelines
Clinical - Initial Assessment	· For MH Providers: Contain a developmental history if the individual is a child. Medicaid children up to 21 non-Medicaid children up to 18	• WAC 388-877A-0130(6) • Clinical Chart	Minimal elements of a developmental history include: • Prenatal experiences • Postnatal experiences • Developmental milestones Or document the attempts to obtain the information if unable to provide.
Clinical – Initial Assessment	Contain sufficient clinical information to determine/justify the diagnosis using criteria in the DSM-5.	WAC 388-877A-0130 (5)(a-b) WAC 388-877B-0330 (8) Clinical Chart	• As described by the individual and/or the person(s) who provide active support to the individual. • The individual's (and/or supportive person's) statements about presenting issues are quoted or paraphrased (e.g., "Client reports…") in the assessment.

Clinical Chart Review: Assessment

Section Titles	Brief Description	Citation	Interpretive Guidelines
Clinical - Initial Assessment	SUD Only: A relapse history;	• WAC 388-877B-0330(4) • Clinical Chart	Described periods of sobriety. Include length, dates, and skills/supports used to maintain sobriety if known. Identify stressors overcome and/or triggers for relapse if known.
Clinical – Initial Assessment	Youth SUD Only: Documented attempts to obtain the following information when assessing youth: Parental and sibling use of drugs;	WAC 388-877B-0330 (12)(a)	Or document the attempts to obtain the information if unable to provide.

Clinical Chart Review: ISP

- Great Rivers Individual Service Plan Tool has a total of 21 unique items
  - 12 General, 4 Mental health only and 8 SUD only items

Section Titles	Brief Description	Citation	Interpretive Guidelines
Clinical – Individual Service Plan	For MH Outpatient providers: Be completed within thirty days from the date of the first session following the initial assessment.	• WAC 388-877A-0135 (1) • Clinical Chart	MH Outpatient: Calculate on basis of 30 calendar days from date of first post-intake session.
Clinical – Individual Service Plan	For SUD Outpatient providers: Be complete before treatment services are received.	WAC 388-877B-0320 (1)(c)	SUD Treatment only.

Clinical Chart Review: ISP

Section Titles	Brief Description	Citation	Interpretive Guidelines
Clinical – Individual Service Plan	Contain measurable goals or objectives, or both.	• WAC 388-877-0620(h) • Clinical Chart	Any goal(s) and/or accompanying objectives linked to a problem either have a measurable goal or a measurable accompanying objective that describes outcomes so that progress can be evaluated…
Clinical – Individual Service Plan	The plan must demonstrate: 1. The individual's Level of Care and specific SMI/SED or ASAM criteria; and 2. The selected interventions are medically necessary, and reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental health or substance use disorder.	• Access to Care Standards • Clinical Chart	Service mix, frequency, intensity and duration on the ISP align with the individual's needs, as assessed by CA/LOCUS, ASAM, or SED/SMI criteria. The individual is expected to benefit from the intervention and any other formal or informal system or support cannot address the individual's unmet needs.

Clinical Chart Review: Progress Notes

- Great Rivers Individual Service Plan Tool has a total of 21 unique items
  - Both Individual and Group progress notes are reviewed

Section Titles	Brief Description	Citation	Interpretive Guidelines
Clinical – Progress Notes	The service addresses an issue on the ISP or issue addressed is added to the care plan. If not on or added to ISP, the reason for unique or brief provision of the service should be documented in the progress note.	• SERI Introduction • Clinical Chart	• Issue addressed during the service must link to an issue, goal or objective on the individual service plan. • Link is documented clearly in the progress note. • If not on or added to ISP, the reason for the deviation from the plan is documented in the progress note.
Clinical – Progress Notes	Group Progress Notes include: Progress towards goals stated in the individual's service plan;	• SERI Introduction • Clinical Chart	Complete for group services notes only.

Audit Reporting

- After the audit, Great Rivers prepares a draft report that is submitted to the BHA for review. At this time, they are invited to provided additional documentation that may have been missed/not reviewed by the auditors during the on-site.

- Great Rivers compiles a Final Report and Corrective Action Plan (CAP) Template, if applicable, to each BHA after reviewing any resubmissions made by the BHA.

- Upon review of the BHA's CAP, Great Rivers accepts the plan and begins monitoring the activities the BHAs plans to accomplish to bring each item into compliance.

Washington State BHA Licensing

- DBHR licenses and certifies treatment programs, and regulates treatment agencies providing services for chemical dependency, community mental health (voluntary and involuntary commitment services), and problem and pathological gambling. The goal is to improve services to vulnerable individuals. When people have access to the behavioral health care they need, it benefits everyone in the community.

- Certification and licensing activities reduce health risks for patients and family members by ensuring that treatment agencies are:
  - Surveyed within 12 months of initial approval and every three years; and
  - In compliance with regulations; and
  - Evaluated rapidly when complaints are received.

Washington State BHA Licensing – Clinical Record

- The initial licensing is based on a mock chart audit review
- Ongoing certification for license is based on a review of the standards outlined in the Washington Administrative Codes
- Each service type has specific WACs that must be meet in addition to the general WAC 388-887.

Washington State Audit Documentation Requirements WAC 182-502-0020

Health care record requirements.

- This section applies to providers, as defined under WAC 182-500-0085 and under WAC 182-538-050. Providers must:
- (1) Maintain documentation in the client's medical or health care records to verify the level, type, and extent of services provided to each client to fully justify the services and billing, including, but not limited to:
- (a) Client's name and date of birth;
- (b) Dates of services;
- (c) Name and title of person performing the service;
- (d) Chief complaint or reason for each visit;
- (e) Pertinent past and present medical history;
- (f) Pertinent findings on examination at each visit;
- (g) Medication(s) or treatment prescribed and/or administered;
- (h) Name and title of individual prescribing or administering medication(s);
- (i) Equipment and/or supplies prescribed or provided;
- (j) Name and title of individual prescribing or providing equipment and/or supplies;
- (k) Detailed description of treatment provided;
- (l) Subjective and objective findings;
- (m) Clinical assessment and diagnosis;
- (n) Recommendations for additional treatments, procedures, or consultations;
- (o) Radiographs (X rays), diagnostic tests and results;
- (p) Plan of treatment and/or care, and outcome;
- (q) Specific claims and payments received for services;
- (r) Correspondence pertaining to client dismissal or termination of health care practitioner/patient relationship;
- (s) Advance directives, when required under WAC 182-501-0125;
- (t) Patient treatment agreements (examples: Opioid agreement, medication and treatment compliance agreements); and
- (u) Informed consent documentation.
- (2) Keep legible, accurate, and complete charts and records;
- (3) Meet any additional record requirements of the department of health (DOH);
- (4) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;
- (5) Make charts and records available to the medicaid agency, its contractors or designees, and the United States Department of Health and Human Services (DHHS) upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation. The agency does not separately reimburse for copying of health care records, reports, client charts and/or radiographs, and related copying expenses; and
- (6) Permit the agency, DHHS, and its agents or designated contractors, access to its physical facilities and its records to enable the agency and DHHS to conduct audits, inspections, or reviews without prior announcement.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455. WSR 13-03-068, § 182-502-0020, filed 1/14/13, effective 2/14/13. WSR 11-14-075, recodified as § 182-502-0020, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0020, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. WSR 01-07-076, § 388-502-0020, filed 3/20/01, effective 4/20/01; WSR 00-15-050, § 388-502-0020, filed 7/17/00, effective 8/17/00.]

Federal CMS and State Requirements for External Quality Review Audits

- Center for Medicare and Medicaid Services (CMS) is committed to combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid enrollees.

- CMS has broad responsibilities under the Medicaid Integrity Program:
  - To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
  - To provide effective support and assistance to states in their efforts to combat Medicaid provider fraud and abuse
  - To elmininate and recover improper payments in accordance with the Improper Payments Information Act of 2002, Executive Order 13520 and the Improper Payments Elimination and Recovery Act of 2010.

  Source: https://www.medicaid.gov/medicaid/program-integrity/index.html)

- The State of Washington has developed a two-tier system to monitor managed care entities (MCEs) that includes a focus on program integrity and involves staff from managed care and quality care management, along with a second=tier review by the state's External Quality Review Organization – Qualis.

External Quality Review

As Washington's Medicaid external quality review organization (EQRO), Qualis Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and the Behavioral Health Organization (BHO) network. Our work supports the Washington State Health Care Authority (HCA) and Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR).

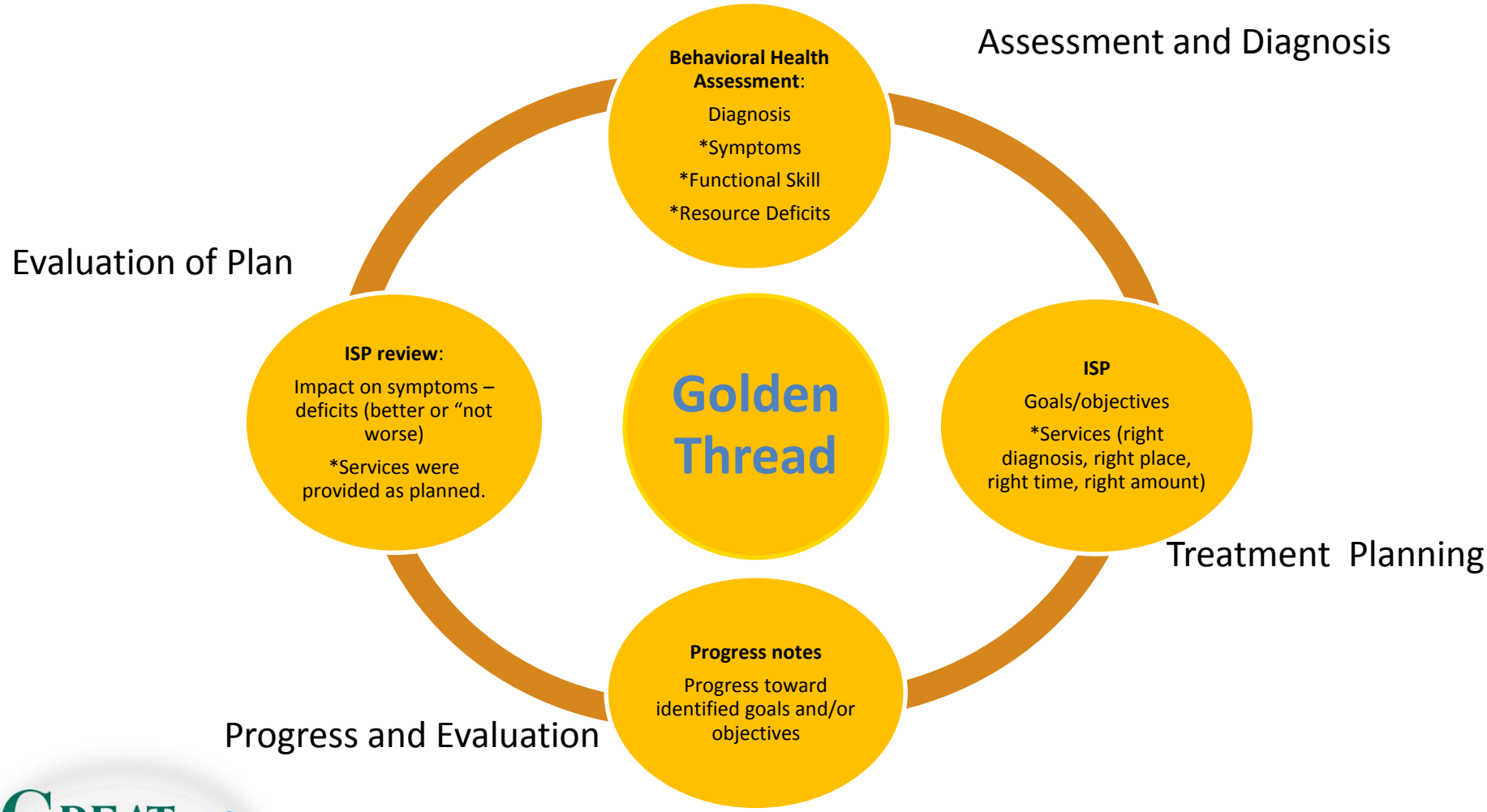
External Quality Review Focus

Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR)

- Qualis Health reviews mental health and SUD services provided by the state's Behavioral Health Organizations (BHOs)—formerly Regional Support Networks (RSNs)—through the following annual activities:
  - Reviewing performance improvement projects (PIPs)
  - Conducting an Information Systems Capabilities Assessment (ISCA) or a follow-up of the previous year's assessment
  - Reviewing compliance with federal regulatory and state contractual standards
  - Validating encounter data submitted by BHOs to the State

Core Element of All Documentation Audits

Golden Thread of Documentation



Know what is Required

- Billing Codes (Service Encounter Reporting Instructions)
- Documentation Required Elements
  - Elements required on an Assessment (ensure Medical Necessity is met)
  - Elements required on the Individual Service Plan
  - Elements required on Progress Notes

Billing Codes = Service Encounter Reporting Instructions (SERI)

- The Behavioral Health Service Encounter Reporting Instructions (SERI) provide Behavioral Health Organizations (BHO) and their contracted Behavioral Health Agencies (BHA) with information for reporting service encounters and program information for individuals served through the Washington state public behavioral health system.

- These instructions, in conjunction with the DBHR Behavioral Health Data Store (BHDS) Data Dictionary for BHOs, describe service encounter and program reporting, coding guidelines, and the data elements BHOs are required to submit to DBHR.

Documentation Required Elements

Reviewing for elements required in documentation

- ❑ Elements required on an Assessment
- ❑ Elements required on the Individual Service Plan
- ❑ Elements required on Progress Notes

Assessment Elements:

1. What is the primary diagnosis? Is it a covered diagnosis?
2. Is the individual's issues clearly in the assessment?
3. Did the assessment incorporate the individual's voice?
4. Is the diagnosis justified by the assessment?

Individual Service Plan

1. Are the problems/concerns identified in the assessment?
2. Does the Individual Service Plan reflect the individual's voice?
3. Are treatment objectives/goals individualized?
4. Are the objectives/goals measurable and time sensitive?
5. Do the goals offer short term progress and long term?
6. Are the interventions individualized and are they aligned with the problems in the assessment?
7. Is there continuity between the assessment and the individual service plan?
8. Are there updates to the individual service plan as treatment goals are reached?

Progress Notes

1. Do the progress notes clearly state the focus of the session/service?
2. Do the progress notes clearly state the intervention used as described in the treatment plan?
3. Do the progress notes reflect the individual's response to the treatment intervention?
4. Do the progress notes reflect progress towards meeting the measurable goals outlined in the individual service plan?
5. Is it clear to the reviewer what the objectives/goals are being addressed by reading the progress notes?

Encounter Data Validation Review

1. Does the service location in the progress match the electronic encounter data?
2. Does the date of the service match the electronic encounter data?
3. Do the minutes of service match the electronic encounter data?
4. Do the name of the service provider match the electronic encounter
5. Do the credentials of the service provider match the electronic encounter data?
6. Does the procedure code match the electronic encounter data?
7. Does the service described on the progress note match the procedure code?

CMS – FACT SHEET

- Behavioral Health services must meet specific requirements for reimbursement.

Documented services must:

- Meet that State's Medicaid program rules;
- To the extent required under State law, reflect medical necessity and justify the treatment and clinical rationale (remember, each State adopts its own medical necessity definition);[4]
- To the extent required under State law, reflect active treatment;
- Be complete, concise, and accurate, including the face-to-face time spent with the patient (for example, the time spent to complete a psychosocial assessment, a treatment plan, or a discharge plan);
- Be legible, signed, and dated;
- Be maintained[5] and available for review; and
- Be coded correctly for billing purposes.

CMS – FACT SHEET

There are some things to avoid as a behavioral health practitioner.

- Never bill "chance, momentary social encounters between a therapist and a patient" as valid therapeutic sessions;
- Never bill undocumented services; and
- Never bill services coded at a higher level than those furnished. For example, if furnishing group therapy, be sure and bill group therapy codes rather than individual therapy codes, and document patient-specific information in each attendee's medical record.

Next Steps for Organizations

Internally:

- Establish a systematic and formal audit process
- Use a Peer Review or other format not including self-audits
- Cover all areas of required by the standards
- Set up regular training modules
- Do Corrective Action Plans (CAPs)
- Develop a data bank and track your progress and compliance

Next Steps for Organizations

External Audit Prep:

- Ensure the Compliance Officer has verified the source of the audit request
- Respond to the audit request as quickly as possible by sending all required information
- If the audit is on site, assist the auditors by having available a mock chart, list of staff signatures, and help them navigate the medical record.
- May need to have copier available and offer assistance in gathering any information
- Ask about the process
- Familiarize yourself with the appeal process and penalties

Reference Material

- Trends in CMS Audits and Enforcement Actions Against Medicare Advantage and Part D Plan – February 2, 2016
- Health Care Auditing Strategies – March 2004, Vol 3 No 3
- MHC – Quality Framework for Mental Health Services in Ireland Audit Toolkit
- Great Rivers BHO BHA Audit Material 2017
- SCPHCA 19th Annual Clinical Network Retreat: Behavioral Health Medicaid Audit Survival by Ligia Latiff-Bolet, Ph.D., SC Department of Mental Health - June 11, 2013
- CMS FACT Sheet - https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf