QI DOCUMENTATION COMPLIANCE TRAINING

AGENDA

- Purpose/Background
  - Documentation and the Government
- Golden Thread
  - Assessments, Individual Recovery Plans, Progress Notes, etc.
- Documentation Guidelines
  - Review Good & Bad examples
- Fraud, Waste, and Abuse
- Key Points
- Quantitative Report
  - How to make it work for you

Healthcare World is Changing!

- The federal government is actively reviewing state AND individual providers with frequent, intensified audits of medical records, contracts, and state policies.
- As the government debates a major revision of healthcare policy, it is looking for funds, and seeks to combat waste, fraud & abuse in current programs.
- Medicaid (and Medicare) is currently one of the largest budget items in the federal budget and many states. Controlling costs by reducing waste and eliminating fraud and abuse is paramount.

AUDITS & PAYBACKS

- Government is recouping hundreds of millions of dollars from providers because of "improper payments" caused by:
  - Missing documentation
  - Billing for services that were not provided
  - Rounding up time
  - Billing for a service that has a higher reimbursement than the service rendered
  - Incomplete documentation
  - Wrong codes for services
  - Services not covered by Medicaid and/or Medicare
  - Content of notes do not substantiate the amount of time billed
  - Overlapping services
  - Bundling multiple inconsecutive services into a single note (eg. Three five minute phone calls may not be bundled to make one 15 minute unit)
  - No Recovery Plan present or the service provided is not adhering to the Plan
- Paybacks are a significant threat to most providers' financial future.

Fraud, Waste and Abuse

- False Claims Act (FCA)
  - Knowingly presents or causes to be presented…a false or fraudulent claim for payment or approval;
  - Knowingly makes, uses or causes to be made or used a false record or statement to get a false claim…
  - Conspires to defraud the funder by getting a false or fraudulent claims paid or approved.
- Fraud may be often interpreted to mean intentional deception in this regard, it can also entail unintentional patterns of errors.
- The State's AG's office and the US Attorney General's Office has the authority to investigate and prosecute Medicaid fraud as contained in the Federal False Claim Act, Federal Civil Monetary Penalty Law and Medical Assistance Provider False Claims Act (State criminal and civil law).

Definitions

FRAUD

- Any intentional deception or misrepresentation made by any staff with the knowledge that the deception could result in an unauthorized benefit to HBH, him/herself or another responsible person.
- **Examples:** billing for services not provided, overlapping services, billing for more time than spent with participant, signing for participants, having participants sign blank forms including Encounter Forms, copying and pasting contents.

Definitions Cont'd

- **WASTE**

  Thoughtless or careless expenditure, consumption, mismanagement, use or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems or controls.

  Examples: misuse of resources, excessive time driving to see multiple participants because of poor planning, am/pm error in writing the time, illegible content, improper error correction.

Definitions Cont'd

- **ABUSE**

  Any practices that are inconsistent with sound fiscal, business, or medical practice and which result in unnecessary cost to the funder, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the contracts, and requirements of state or federal regulations) for health care in the managed care setting.

Definitions Cont'd

- **ABUSE Examples:** missing treatment/recovery plans, services provided do not follow the recovery plan, notes do not substantiate time billed, inadequate documentation in health record, missing documentations for services billed, billing for therapeutic services while only non-therapeutic services were provided, missing participant signatures, notes missing clinical/therapeutic interventions

FWA Reporting

- Any HBH employee (full-time, part-time, or contract personnel) who has knowledge of an occurrence of fraudulent conduct, or has reason to suspect that a fraud has occurred, must immediately notify the Compliance Officer, Roland Jacobsen.
- It is HBH's intent to investigate any suspected acts of fraud, misappropriation or other similar irregularity. An objective and impartial investigation, as deemed necessary, will be conducted regardless of the position, title, length of service or relationship with HBH of any person(s) who might be involved in such an investigation.

Compliance Processes

- In the event of fraud, a thorough internal investigation must be completed.
- If the investigation results confirm that fraud was committed for billed items, the funding source will be notified by the Compliance Officer.
- Depending on the extent of the fraudulent activity (eg. Billing for services that were not provided), the Attorney General's office may be contacted.
- All unsubstantiated funds must be reimbursed to funder
- HH may chose to pursue legal action against the employee

DOCUMENTATION: GOLDEN THREAD

- Each piece of documentation must flow logically from one to the next
- The assessment must be completed before the recovery plan. The assessment must be coherent, cohesive, & establish medical necessity, and must identify symptoms & behaviors to be addressed in the recovery plan.
- The recovery plan is developed from the areas of need identified in the assessment.
- Progress notes must flow from the recovery plan & document both the services provided and the participant's response to the interventions (DIRP or the SOAP for MDs).
- The recovery plan review/update is guided by the progress indicated in the notes
- The cycle continues until discharge.
- If accurately followed, documentation will support each decision, intervention, & progress—It contributes to a complete record of the participant's care
- Work must be completed with utmost accuracy and soundness of judgment to avoid any fraud, waste or abuse.

ASSESSMENTS

- Ensure that the forms are completely filled out
  - Participant's name and one other identifying info on every page
  - Sign and date with Credentials and Title
  - Never use N/A – everything is applicable
  - Evidence-based tools are used
- Should be strength/recovery based
- Information from the assessments should be used to develop the goals on the recovery plan.

PROGRESS NOTES

- Program should deliver services according to the nature, frequency, and intensity 'prescribed' in the IPOS.
- Progress notes support specific claims & justify payment
- Progress notes provide evidence of:
  - **the reason for the visit and services provided**
  - **the current status of the participant (including symptoms or behaviors)**
  - **interventions used by staff**
  - **the individual's response to the treatment**
  - **progress toward the goals & objectives**
  - **on-going analysis of treatment strategy & needed adjustments**
  - **clinical justification to support continued need for services (medical necessity) and the plan going forward.**

PROGRESS NOTES

- Must be entered into ELMER
- Notes must be written by end of shift
- Must include therapeutic interventions and progress
- Should not use vague language like ‘little progress’ or ‘fair’, without elaborating.
- Must include the date (month/day/year) as well as start and end times with am/pm
- Notes and signatures must be legible (signature stamp prohibited).
- No duplication of content - copy and paste (or progress notes containing only a few sentence changes, or a few words changed from prior notes)
- Must include the location where service was provided.

PROGRESS NOTES

- Must include the name(s) of the individuals(s) who rendered the services
- There should be sufficient content in progress notes to substantiate the length of time billed.
- All communication with collateral on behalf of participants must be documented.
- When an incident occurs, document the facts of the occurrence.
- For group notes, the assessment and plan section cannot be copied, only the generic data (date, time, staff present, participants present, topic)
- Progress at each visit, any change in status or diagnosis, changes in treatment and response to treatment, next steps to justify continued services;

PROGRESS NOTES

- **Addendum**

  An addendum is used to provide additional information to a record. When making an addendum:

  - Document the current date and time.
  - Write “addendum” and state the reason for it, referring back to the original entry.
  - Identify any sources of information used to support the addendum.
  - When writing the addendum, complete it as soon after the original note as possible.

PROGRESS NOTES

- **Entering a Clarification**

  A clarification note is written to avoid incorrect interpretation of information that has been previously documented. To make a clarification entry:

  a. Document the current date and time.

  b. Write "clarification," state the reason, and refer back to the entry being clarified.

  c. Identify any sources of information used to support the clarification.

  d. When writing a clarification note, complete it as soon after the original note as possible.

PROGRESS NOTES

- **Altering the Health Records**

  It is considered falsification to go back and fill in signature “holes” in the health record. Records should not be audited after a period of time with the intent of filling in “holes.”

PROGRESS NOTES

- **Documenting Care Provided by a Colleague**

  Documentation will be authenticated. When a staff member is notified that a colleague forgot to record something in the record, the staff member is to enter the date and time of the notification along with the entry. The note should be signed by the staff member who wrote it. When the colleague returns, he/she will review the note for accuracy and countersign it.

DOCUMENTATION GUIDELINES

- Do not use the wrong participant's name in the progress notes, treatment plans or assessments
- Avoid improper error correction in record – only a single line should be drawn through the error with staff initials and date (the inaccurate information must remain visible (~~Example)~~. For correction on dates, draw a single line and write error with staff initials. Never attempt to bold-print over the error.
- Never use white-out in the health record
- Never use highlighters in the health record
- Only document in black ink (never use pencil or erasable ink).
- All documents must be signed with date, credentials and title
- All information must be legible
- Each page must have the participant's name and DOB
- Do not use 'not applicable' in the chart if the information applies but is not available.
- All documents must be completely filled out

DOCUMENTATION GUIDELINES

- Entries should never be pre-dated or post-dated.
- Staff should never sign an entry that someone else made
- The health record should only contain factual and objective information pertinent to the direct care of the participant. It should not contain emotional feelings, statements of accusation, complaints about any healthcare worker, the program, or staffing issues.
- Use recovery language when documenting in the record.

DOCUMENTATION GUIDLINES

- Do not use jargon in the record
- Do not use unapproved abbreviations
- Do not use language that the participant may find offensive or disrespectful
- Never remove the record from the program without the prior authorization of the program director.
- Documenting non-billable services is still necessary but cannot be submitted for payment.
- Do not round up time. Document the exact start and end time.
- Do not bundle multiple calls into a single billable note

Variance Concerns

- Missing documentation – items billed but no documentation (such as progress/group notes) to support
- Missing treatment plans – all services provided during the missing tx plan timeframe are not billable (For PGPs, this would include the Monthly Updates).
- Contents of the Treatment Plan not followed
- Missing start and end times on progress notes – should include ‘am’ or ‘pm’
- Missing signatures on documentation

Variance Concerns

- Duplication of content in documentation such as progress notes and treatment plans.
- Illegibility of content such as progress notes or treatment plans
- Missing clinical interventions in progress notes
- Group note contents copied, (only the generic data can be copied).
- Improper correction in record – only a single line should be drawn through the error with staff initials and date

Variance Concerns

- Using the wrong participant's name in the health record
- Billing for participants who did not attend a group
- Billing for excessive amount of time when participants are not present for a field session and staff speak to collateral contact.

Quality of Care Concerns

- Medication lists not up to date
- Recovery Plan not being followed
- Conflicting clinical information
- Male referred to as female or vice versa

Program Management staff must ensure that Service Verification is being done consistently for all field services

Main Administrative Concerns

- Missing signature and date
- Legibility
- Incorrect error correction
- Beginning and end times missing
- Missing correct location
- Incomplete forms
- Inconsistent diagnoses in charts

KEY TAKEAWAY POINTS

- Be your own auditor
- Have a recovery plan and follow it
- Pay close attention to detail
- Everything gets filled out. Leave no blanks!
- Correct errors properly
- Document EVERYTHING

Remember… we should hold ourselves accountable, and our health records should be a reflection of the wonderful services we provide!