Provider Training Series
The Search for Compliance

May 1, 2013

Training #1 – Provider Responsibilities

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Value Behavioral Health of Pennsylvania
A ValueOptions Company

Compliance

Introduction

VALUE BEHAVIORAL HEALTH of PENNSYLVANIA
A VALUEOPTIONS COMPANY

Why Compliance?

- Required by Law
- Avoid High Risk to Individuals and Agencies:
  - False Claims Act
    - Exclusion from participation in any federal programs
    - Prison
    - Corporate Integrity or Deferred Prosecution Agreement
    - Criminal: $250,000 individuals/$500,000 companies
    - Civil: $11,000/claim, plus 3x the amount of each claim
  - HIPAA/HITECH Act—Civil and Criminal Penalties based on intent
  - Sanctions/loss of contracts
  - State False Claims Acts and Privacy/Security Laws
  - Impaired business reputation
  - Financial loss from provider billing errors and potential fraud.

Requirements of Compliance

1. High level support and authority
2. Written standards
3. Training and education
4. Culture of open communication
5. Monitoring and auditing
6. Consistent enforcement and discipline of violations
7. Appropriate response to detected problems
8. Effective compliance program

VBH-PA Compliance Program

- **Compliance Program –** A formal program that supports VBH-PA (ValueOptions) goal that all employees and board members are aware of and act in compliance with applicable laws and promote adherence to ethical standards.

- **Compliance Department –** Responsible for performing daily oversight and assessment of the effectiveness of the Compliance Program and recommending changes/improvements as necessary.

VBH-PA Provider Training

VBH-PA Compliance Training

- Previous 2011 and 2012 Provider Trainings
  - http://www.vbh-pa.com/fraud_abuse.htm
- 2013 Provider Trainings
  - More specific and concentrated topics
  - More technical assistance

2013 Provider Training Series

The Search for Compliance

- The webinar series will include:
  - Compliance and regulation technical assistance on specific topics
  - Provider Question and Answer (Q&A) session on compliance
- The topics and Q&A sessions of the webinar series will assist providers with the search for compliance. The webinar series will focus on compliance topics, such as, locating the regulations, keeping complete medical records, preparing for oversight audits, achieving specific level of care requirements, and determining Medicaid billable and non-billable activities.

Provider Responsibilities: Treatment Plans & Documentation Requirements

Training #1

VALUE BEHAVIORAL HEALTH of PENNSYLVANIA
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Provider Responsibilities

1. Locating Sources
2. Defining Requirements
3. Auditing and Monitoring for Compliance

Provider Responsibilities

- Treatment/Service Plan Requirements
- Documentation Requirements

Locating Sources

State:

- Pennsylvania Code www.pacode.com
  - Chapter 5100. Mental Health Procedures
- PA Medical Assistance Bulletin www.dpw.state.pa.us
  - March 2002 Documentation Requirements

Federal:

- 42 CFR www.gpo.gov
  - Program Integrity Requirements for Medicaid
- Centers for Medicare and Medicaid (CMS) www.cms.gov
  - Medicaid Documentation Requirements

BH-MCO:

- VBH-PA Provider Manual www.vbh-pa.com
  - Documentation Guide (All providers)
  - Provider Information Section

Defining Requirements

PA Code

PA Code 55 Chapter 5100 Mental Health Procedure

§ 5100.13. Responsibility for formulation and review of treatment plan.

(a) The director of the treatment team shall assure that staff trained and experienced in the use of the modalities proposed in the treatment plan participate in its development, implementation and review.

(b) The director of the treatment team shall be responsible for:

(1) Insuring that the person in treatment is encouraged to become increasingly involved in the treatment planning process.

(2) Implementing and reviewing the individualized treatment plan and participating in the coordination of service delivery with other service providers.

(3) Insuring that the unique skills and knowledge of each team member are utilized and that specialty consultants are utilized when needed.

(c) Although a treatment team must be under the direction of either a physician or a licensed clinical psychologist, specific treatment modalities may be under the direction of other mental health professionals when they are specifically trained to administer or direct such modalities

Defining Requirements

PA Code

PA Code 55 Chapter 5100 Mental Health Procedure

§ 5100.15. Contents of treatment plan.

(a) A comprehensive individualized plan of treatment shall:

(1) Be formulated to the extent feasible, with the consultation of the patient. When appropriate to the patient's age, or with the patient's consent, his family, personal guardian, or appropriate other persons should be consulted about the plan.

(2) Be based upon diagnostic evaluation which includes examination of the medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental aspects of the patient's situation.

(3) Set forth treatment objectives and prescribe an integrated program of therapies, activities, experiences, and appropriate education designed to meet these objectives.

(4) Result from the collaborative recommendation of the patient's interdisciplinary treatment team.

(5) Be maintained and updated with progress notes, and be retained in the patient's medical record on a form developed by the facility and approved by the Deputy Secretary of Mental Health, as part of the licensing approval process.

(b) The treatment plan shall indicate what less restrictive alternatives were considered and why they were not utilized. If the plan provides for restraints, the basis for the necessity for such restraints must be stated in the plan under Chapter 13 (relating to use of restraints in treating patients/residents).

(c) Individual treatment plans shall be written in terms easily explainable to the lay person and a copy of the current treatment plan shall be available for review by the person in treatment.

(d) When the most appropriate form of treatment for the individual is not available or is too expensive to be feasible, that fact shall be noted on the treatment plan form.

Defining Requirements

PA Code

PA Code 55 Chapter 5100 Mental Health Procedure

§ 5100.16. Review and periodic reexamination.

(a) At least once every 30 days, every person in treatment under the act shall have his treatment plan reviewed. This review shall be based upon section 108(a) of the act (50 P. S. § 7108(a)). A report of the review and findings shall be summarized in the patient's clinical record.

(b) The decisions and redisposition required by section 108(b) of the act, based upon such reexamination and review, shall be recorded in the patient's clinical record as either a progress note or in any other appropriate form acceptable to the agency's records committee.

(c) Such record shall include information required by section 108(c) of the act.

Defining Requirements

PA Code

Provider Responsibilities PA Code 55 Chapter 1223 Outpatient Drug and Alcohol Clinic Services

1223.42. Ongoing responsibilities of providers.

(a) Ongoing responsibilities. Ongoing responsibilities of providers are established in Chapter 1101 (relating to general provisions).

(b) Record keeping requirements. In addition to the requirements listed in Chapter 1101, the following items shall be included in medical records of Medical Assistance patients receiving drug/alcohol outpatient clinic services:

(1) As part of the treatment plan, the treatment plan goals; services to be provided to the patient in the clinic or through referral; and persons to directly provide each service shall be included.

(2) As part of the progress notes, the frequency and duration of each service provided shall be included

Defining Requirements

PA Code

Provider Responsibilities Chapter 55 § 1101.51 (d) establish standards of practice

(d) *Standards of practice.* In addition to licensing standards, every practitioner providing medical care to MA recipients is required to adhere to the basic standards of practice listed in this subsection. Payment will not be made when the Department's review of a practitioner's medical records reveals instances where these standards have not been met.

(1) A proper record shall be maintained for each patient. This record shall contain, at a minimum, all of the following:

(i) A complete medical history of the patient.

(ii) The patient's complaints accompanied by the findings of a physical examination.

(iii) The information set forth in subsection (e)(1).

(2) A diagnosis, provisional or final, shall be reasonably based on the history and physical examination.

(3) Treatment, including prescribed drugs, shall be appropriate to the diagnosis.

(4) Diagnostic procedures and laboratory tests ordered shall be appropriate to confirm or establish the diagnosis.

(5) Consultations ordered shall be relevant to findings in the history, physical examination or laboratory studies.

(6) The principles of medical ethics shall be adhered to.

Defining Requirements

PA Code

Provider Responsibilities Chapter 55 § 1101.51 (e) establish record keeping requirements for all provider types

(e) Record keeping requirements and onsite access. Providers shall retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA recipients and that meet the criteria established in this section and additional requirements established in the provider regulations. Providers shall make those records readily available for review and copying by State and Federal officials or their authorized agents. Readily available means that the records shall be made available at the provider's place of business or, upon written request, shall be forwarded, without charge, to the Department. Providers who are subject to an annual audit shall submit their cost reports within 90 days following the close of their fiscal years. If the Department terminates its written agreement with a provider, the records relating to services rendered up to the effective date of the termination remain subject to the requirements in this section.

Defining Requirements

PA Code

Provider Responsibilities Chapter 55 § 1101.51 (e) establish record keeping requirements for all provider types, continued

(1) General standards for medical records. A provider, with the exception of pharmacies, laboratories, ambulance services and suppliers of medical goods and equipment shall keep patient records that meet all of the following standards:

(i) The record shall be legible throughout.

(ii) The record shall identify the patient on each page.

(iii) Entries shall be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record shall be signed and dated.

(iv) The record shall contain a preliminary working diagnosis as well as a final diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

(v) Treatments as well as the treatment plan shall be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages shall be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to this effect.

(vi) The record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment.

(vii) The record shall contain summaries of hospitalizations and reports of operative procedures and excised tissues.

(viii) The record shall contain the results, including interpretations of diagnostic tests and reports of consultations.

(ix) The disposition of the case shall be entered in the record.

(x) The record shall contain documentation of the medical necessity of a rendered, ordered or prescribed service.

Defining Requirements

PA Code

Provider Responsibilities PA Code 55 § 1101.51 (e) establish record keeping requirements for all provider types, continued

(2) Fiscal records. Providers shall retain fiscal records relating to services they have rendered to MA recipients regardless of whether the records have been produced manually or by computer. This may include, but is not necessarily limited to, purchase invoices, prescriptions, the pricing system used for services rendered to patients who are not on MA, either the originals or copies of Departmental invoices and records of payments made by other third party payors.

(3) Additional record keeping requirements for providers in a shared health facility. In addition to the record keeping and access requirements specified in this subsection, practitioners and purveyors in a shared health facility shall meet 1102.61 (relating to inspection by the Department).

(4) Penalties for noncompliance. The Department may terminate its written agreement with a provider for noncompliance with the record keeping requirements of this chapter or for noncompliance with other record keeping requirements imposed by applicable Federal and State statutes and regulations.

Defining Requirements

Medical Assistance Bulletin

March 2002 Documentation and Medical Record Keeping Requirements

Providers must develop a treatment plan which contains a written description of the treatment objectives related to the individual's diagnosis and includes the specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives. The treatment plan must be included in the patient's record and the treatment objectives must state:

1. A projected schedule for service delivery which includes the expected frequency and duration of each planned therapeutic session;
2. The name(s) of the individual(s) who will be delivering the services;
3. The schedule for completing a reassessment of the individual's status in relation to the individual's diagnosis and treatment goals and objectives; and
4. The schedule for updating the treatment plan.

Defining Requirements

Medical Assistance Bulletin

March 2002 Documentation and Medical Record Keeping Requirements

The documentation of treatment or progress notes, at a minimum, must include:

1. The specific services rendered;
2. The date that the service was provided;
3. The name(s) of the individuals(s) who rendered the services;
4. The place where the services were rendered;
5. The relationship of the services to the treatment plan, specifically any goals, objectives and interventions;
6. Progress at each visit, any change in diagnosis, changes in treatment and response to treatment; and
7. The actual time in clock hours that services were rendered. For example: the recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:00 A.M. to 11:00 A.M.

Auditing & Monitoring

- All providers are responsible to ensure all documentation is accurate and complete
- All providers are responsible to conduct self-audits
  - DPW recommends provider conduct self-audits so that additional penalties are not accessed for overpayments
    - http://www.vbh-pa.com/providers.htm

Auditing & Monitoring

VBH-PA Audit Tools

Quality Documentation Audit Tools

- There must be a treatment plan for payment, and the treatment plan must meet PA Code including the following:
  - Initial plan
  - Must be individualized per the initial assessment and diagnosis
  - Must have measurable goals and objectives with specific timeframes
  - Signed by the clinician/treatment team
  - Signed by the member
  - Periodic plan reviews depending on the level of care
- The progress notes must reflect the treatment plan goals

Auditing & Monitoring

VBH-PA Audit Tools

Claims Billing Tool

- All progress notes must meet the following requirements for payment:
  - Name or MA Id
  - Date of service
  - Start and stop times of service
  - Units match the claims billing
  - Place of service
  - Narrative that includes all clinical requirements (as stated above)
  - Clinician signature, credentials, and signature date
  - All requirements are legible
  - All requirements are complete prior to claims billing date
- All encounters must have an encounter form
- All requirements must be completed and dated prior to claims submission date

Auditing & Monitoring

VBH-PA Audit Tools

Clinical Documentation Assessment Tool

- All progress notes must meet the clinical documentation standards and the following requirements for payment:
  - Reason for the session/encounter
  - Treatment goals addressed
  - Current symptoms and behaviors
  - Interventions and response to treatment
  - Next steps and progress in treatment
  - Clinical justification to support utilization
  - Supporting documentation, when applicable

Auditing & Monitoring

VBH-PA Audits

- For payment, all encounters for all providers must meet treatment plan and documentation requirements
- For ALL provider types, for payment, at a minimum, the member record must include
  - Treatment Plan
    - Initial and periodic reviews that support the dates of services
  - Progress Note
    - Every encounter
  - Encounter Form
    - Every encounter

Q&A Session

Please feel free to ask questions related to compliance

The Search for Compliance, Continues

Make sure you are registered for the ValueAdded at

http://www.vbh-pa.com/providers.htm

VALUE BEHAVIORAL HEALTH of PENNSYLVANIA
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Future Webinars

Wednesday, May 22, 2013 10:00AM

Documenting and Billing Outpatient Psychotherapy

- Individual and group
- Evaluation and management

Future Webinars

Tuesday, June 11, 2013 10:00AM

Recipient Verification Requirements

- Encounter forms
- Member verification surveys

Future Webinars

Tuesday, June 25, 2013 10:00AM

Provider Self-Audits

- DPW and CMS requirements
- VBH-PA self-audit forms

Thank You

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