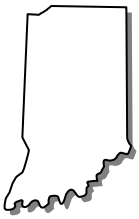
INDIANA HEALTH COVERAGE PROGRAMS



PROVIDER BULLETIN

BT200603 FEBRUARY 23, 2006

To: **Community Mental Health Center Providers (Specialty 111)**

Subject: **Surveillance and Utilization Review Recommended Internal Audit Guidelines**

Overview

This bulletin outlines the basic elements that the Health Care Excel (HCE) Surveillance and Utilization Review (SUR) Department reviews during audits. Providers seeking to develop or strengthen their internal audit process may find assistance in this document and the *IHCP MRO Provider Manual*. Development of an internal audit process is voluntary and compliance with the recommendations listed in this bulletin does not imply or ensure the avoidance of SUR audit findings.

This bulletin serves to assist providers in developing and strengthening their internal audit process to enhance compliance with the Indiana Health Coverage Programs (IHCP) requirements. The Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health and Addiction (DMHA) strongly recommend this information be incorporated into the provider's own compliance program.

Documentation Reviewed During a SUR Audit

Required Documents

The following parts of the **individual patient's medical record** are considered essential to support services billed. Additional requirements are located in the *IHCP MRO Provider Manual*.

- Clinical assessments
- Treatment plans
- Documentation of physician or Health Service Provider in Psychology (HSPP) oversight
- Service notes

SUR may request or consider other types of documentation to provide *additional* support of services rendered. **However, this additional documentation is not sufficient to stand alone to support billing services to the IHCP.** Providers must maintain documentation independent of the following items, which meet IHCP requirements for the respective service billed:

- Service activity logs (SALS)
- Staffing records (records kept when cases are staffed or reviewed with the physician or HSPP providing oversight of services)

- Appointment logs or records
- Employee time records

At the **provider level**, a *Clinical Plan for Professional Services* **must be maintained**. The IHCP requires that all Medicaid rehabilitation option (MRO) providers maintain and update a *Clinical Plan for Professional Services*. The *Clinical Plan for Professional Services* is a provider, facility, and program-specific document. Each Community Mental Health Center (CMHC) must maintain and update this document to serve as a supplemental support that will be reviewed during a SUR audit. At a minimum, the CMHC's *Clinical Plan for Professional Services* must address the references to the document within the *IHCP MRO Provider Manual.* In addition, the *Clinical Plan for Professional Services* must meet all DMHA requirements as outlined in *440 IAC.*

SUR recommends that providers maintain the documents listed in Table 1 as support of services rendered in addition to *(but not in lieu of)* specific medical record documentation. SUR-identified concerns with providers' ability to maintain and produce specific types of documentation that support accurate record keeping and credential verification. The documents listed in Table 1 should be incorporated in any internal record documentation integrity system and be updated regularly as SUR typically requests these documents during an audit.

Table 1 – Documents Requested by SUR

Document	Purpose	Recommended Updates
Standard Abbreviations List	Clarify each service noted on the treatment plan and within the record documentation	Update annually, at minimum.
Description of Service(s) and Program(s) Unique to the Provider	Describe the particular program or services that may differ from other CMHC programs or that are outside the scope of service usually allowable under the program	Update upon development and with significant revisions to program operations.
Employee List with Signatures	Include verification of staff signature and credentials (may be done through separate process)	Develop master list (if not already in existence) and update at least monthly as employees hire, terminate, or change position, credentials, or licensure. Reconcile the master list annually to ensure the accuracy of current and historical information.

Ways To Focus an Audit for Compliance

SUR recommends that providers use a combination of approaches to analyze billed services to ensure overall compliance. While many traditional internal audit programs focus on comparing a list of billed services to the medical record to ensure documentation is present, this method alone does not consistently reveal the types of utilization concerns that SUR often discovers. The CMHC should consider additional methods for review of services when developing a comprehensive internal audit program. Areas or domains to focus a review may include the following:

1. Physician or HSPP oversight
   - Evaluate the reasonableness of a specific provider's ability to adequately oversee the volume of assigned cases.
   - Analyze the treatment plans and frequency of services under a particular provider's oversight as compared to the provider's peers.
2. Qualified Mental Health Professional (QMHP)
   - Evaluate all services reviewed by each QMHP for patterns.

3. Case manager
   - Compare services billed to hours worked.
   - Evaluate all notes and services for a specific day or week for overlapping times (duplicate billing).
4. Special program(s)
   - Review all services billed in a particular program.
5. Family unit
   - Review for overlap of services or duplication of billing services between family members

Audit Process Recommendations and Sample Audit Tool for Developing an Internal Audit Program

Figure 1describes the basic course that a retrospective internal audit may follow, outlined in three phases. The phases may be conducted in whichever order is determined to be most beneficial by the auditor. Audits may be conducted by a staff member familiar with the provider's internal audit process or an outside party contracted by the provider.

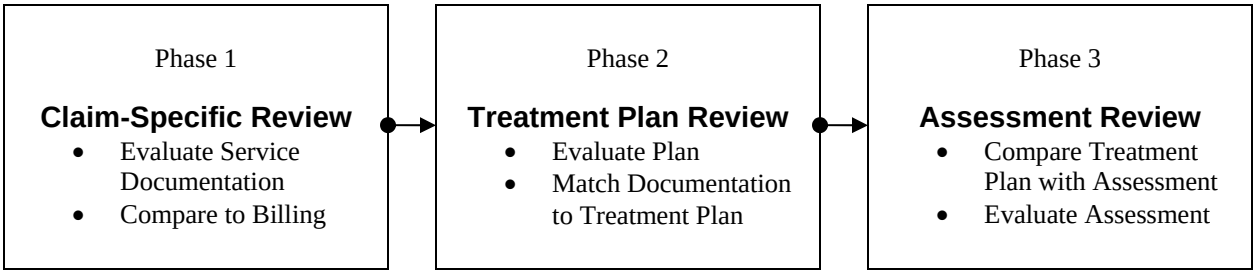


Figure 1 – Internal Audit Process

Table 2 provides a list of questions that may assist providers conducting an internal audit. In addition, this sample tool includes some reminders of staff educational topics that might require reinforcement.

Table 2 – Sample Questions for an Internal Audit

Phase 1 – Claim-Specific Review
Is documentation present to support the specific service billed on the identified date of service? Does the date of service billed match the date of service documented? Is there any contradiction to the billing, such as a note of cancellation of appointment?
Is the documentation legible?
Is the documentation authenticated (signed) and dated by the person who rendered the service? Can the signature be easily read or verified by a facility signature list? Are the appropriate credentials used? If not, is verification of credentials available? → *Educate staff regarding inclusion of credentials with signature.*
If the service was rendered by any person other than a physician or HSPP, was the service billed with the correct accompanying modifier(s)?
Is the number of units billed for each individual service supported by the documentation?
For MRO services, were the minutes in service to the client appropriately compiled throughout the day for each procedure code billed?

(Continued)

Table 2 – Sample Questions for an Internal Audit

Phase 1 – Claim-Specific Review
If the procedure code billed was based on time spent in service to the member, is the time spent verified by the documentation? If not, is there additional documentation (e.g., appointment books, service activity logs) available to verify the time spent? → *Educate staff regarding supportive documentation for time sensitive codes.*
Does the content of the note – actual service documentation – accurately match the procedure code billed? → *Be sure to reference any applicable IHCP publications regarding code use or clarification for MRO codes.* → *Ensure compliance with CPT coding guidelines for CPT (Clinic) codes.*
If a late entry is made in the record documentation, is it appropriately documented per provider policy and in compliance with SUR recommendations?
Phase 2 – Treatment Plan Review
Is the plan legible?
Is a treatment plan present indicating that services rendered were authorized as medically necessary by the physician or HSPP?
Was the treatment plan authenticated by a physician or HSPP within 90 days prior to the service being rendered?
Did the member see the physician or HSPP within 90 days prior to the service being rendered?
Was the service rendered authorized on the treatment plan?
Is the treatment plan evaluated to ensure that the services rendered are in the frequency deemed necessary by the patient's needs?
Is the treatment plan developed logically based upon all assessments (e.g., diagnostic impressions, psychological evaluations) of the patient?
Phase 3 – Assessment Review
Was an initial assessment of the patient performed, or reviewed by, the physician or HSPP within seven days of introduction to services?
Have subsequent assessments been performed as changes in the member's condition were noted?
Does the assessment(s) support the diagnoses identified?
Does the assessment(s) support the medical necessity of the treatment plan that was developed and the specific treatment modalities ordered?

Adjusting Claims Subsequent to SUR Audit Notification

Often, during the process of producing record documentation for an upcoming SUR audit, the provider completes an internal review and confirms a billing error. Providers then submit paid claim void or replacement to return overpayments to the IHCP subsequent to notification of a SUR audit.

Due to existence of the billing error when SUR identified the claim for review and when notification was sent to the provider, the net overpayment amount will be included in the extrapolation process. If the adjustment has been completed and the overpayment refunded to the IHCP at the time the SUR findings are completed, the net amount will be deducted from the final extrapolated total. If the provider can substantiate that the claim was identified and voided or replaced **prior to notification of the SUR audit**, consideration will be given to removing the claim from the extrapolation process.

Additional Information

For more information about topics covered in this bulletin, refer to the *IHCP MRO Provider Manual* available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Manuals/Other/MRO_Provider_Manual.pdf.

Contact Information

Questions regarding SUR audits may be directed to the Health Care Excel (HCE) SUR Department by calling (317) 347-4527 Indianapolis local area, or 1-800-457-4515 toll free.

Written correspondence should be sent to the following address:

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