Sample Baseline Review Report

The following is based on a review of policies, procedures and medical records to determine basic knowledge of and adherence to compliance standards as they relate to documentation, billing, coding and compliance plan.

Compliance Plan

We have reviewed provisions relating to billing and payment in Any Agency's *Compliance Plan* (the "Plan"), which serves in part as Any Agency's Compliance Plan. We did not review the Plan's provisions relating to HIPAA privacy and security standards, professional conduct and child abuse and neglect, because detailed provisions relating to this topic are not typically included in a compliance plan. We have detected several potential deficiencies in the compliance portion of the Plan, although not all deficiencies are discussed in this report. Some key deficiencies include:

Title. The Plan should be specifically identified as a compliance plan, as well as a code of conduct. This is because enforcement agencies usually want to know whether an agency has a compliance plan and in what form it resides. This would make its purpose clear and make it easier for employees to identify its existence.

***Unfulfilled Commitments*.** There are a number of commitments in the Plan that are not being routinely complied with by Any Agency. For example, the Plan refers to audits of billings that, we understand, have not been done. We also understand that a utilization review program has not been fully implemented. Unfulfilled commitments in a compliance plan actually increase the risk of an adverse outcome in a government audit or investigation and may add exposure to liability. The commitments may be interpreted as "representations" made by the agency, and failure to comply may be used to establish a "knowing" violation of law, thus increasing the potential penalties. It is preferable to make the plan conform to actual practices, and where Any Agency intends to enhance compliance in the future, it can be so noted.

***Description of Laws*.** The description of laws applying to billing conduct is incomplete. Some definitions are missing such as "federal healthcare plan". Several key laws are not identified. It would also be preferable to add a brief summary of the "layman's" understanding of each law.

***Accountability to the Board of Directors*.** The Plan does not establish sufficient accountability to the Board of Directors for compliance activities. Currently, the plan includes an annual report of recommendations to changes in the compliance plan and compliance activities. The frequency of reports to the Board should be at least quarterly. The Board of Directors should approve any changes to the compliance plan. You may want to establish a Board liaison to the compliance committee or compliance officer.

Billing Policies. The Plan should cross-reference billing policies, such as policies regarding balance billing, credit balances, collection of self-pay balances, billing documentation and coding, controls for proper billing, background checks (for employees, volunteers and agents), investigation of non-compliance specifically for billing misconduct, employee sanctions for not complying with the Plan (specifically added to the Human Resource manual), whistleblowers, internal audits of billings, and billing records retention. Some of these policies may exist elsewhere, but we

were not provided with any billing-related policies. If they exist, they should be reviewed for accuracy and consistency with the Plan.

***Reporting and Cooperation Requirements*.** The Plan should state in a highlighted form an affirmative obligation on the part of employees to report observed misconduct in billing, to call the compliance officer with questions if uncertain of proper procedures, and to cooperate with the compliance officer in training and investigations. In the current Plan, there was no affirmative obligation to contact the compliance officer and to cooperate with his/her investigations.

Training. The training section of the Plan should state that training will be provided for specialized functions such as coding. It should also have a specific time period for retraining of employees in compliance, e.g., every two years.

***Gifts*.** There should be a dollar limit for gifts, and standards should be introduced (other than simply approval of supervisor) for entertainment.

Audits. Specific provisions should be added to describe an audit program.

Documentation, Billing and Coding

The following findings result from a record review of 50 randomly selected charts:

Billing and Coding

- Documentation in a majority of cases did not meet accepted standards for the codes utilized.
- All records reviewed except for one had progress notes for each date of service billed. One record revealed that on 1/4/08 a 90806 was billed and paid with no progress note in the record for that date of service.
- Services billed matched the coding that was presented.

Medical Necessity

Medical necessity is determined by the documented reasonableness of the delivered service based on identified treatment goals and continuing progress towards those goals. Each note is required to stand alone as medically necessary. This type of progress was not evident in the documentation of the reviewed records.

Medical Record Documentation

The documentation in each record was reviewed for consistency between the treatment plan and the ongoing progress notes. This included both therapeutic and psychopharmacological interventions, reasonableness and necessity of services, and issues of legibility and completeness of required recordkeeping.

Treatment Plans

There are several areas of concern in relation to the treatment plan.

- Diagnoses are listed as the problem.
- Goals are not measurable.
- Frequency and duration of treatment are not noted.
- MD signatures are missing in the majority of the records reviewed.
- Several records have no treatment plans, nor 90 day reviews.
- Several records were dated 2005 instead of 2007.
- When there are signatures on the treatment plan, all of the signatures of the multidisciplinary team are signed on different dates.
- One record contained a more appropriate one page 90 day review form that was not found in the other records.

Progress Notes

- Progress notes showed consistent deficiencies which were more notable for practitioners who were not independently licensed.
- Progress notes were lengthy and narrative with rambling sentences that were not related to the treatment plan.
- There was no evidence of medical necessity.
- The progress notes were not written in behavioral terms and did not document progress or lack of progress towards the identified goals
- Documentation is, generally weak and nonspecific.
  - Example: A progress note for a 6 year old client states: "Establish treatment goals and objectives re: treatment plan, explain confidentiality, attendance policy. Begin to establish rapport with client." There was no evidence of medical necessity for a case consult or family therapy. The progress notes bore no relation to the treatment plan.
  - Example: A progress note stated that the patient displayed a decrease in verbal aggressive behavior. Questions arise as to how that item was measured and/or how much of a decrease was noted.

90 Day Reviews

- Do not reflect the treatment plan
- Are not always timely
- Are not specific as to progress towards goals or target dates for meeting goals
- Do not define ongoing goals

Utilization Review

The majority of the records reviewed did not contain UR documentation. The records that contained UR documentation revealed the following areas of concern:

- The UR form is checked yes for progress note and treatment plan, but the content is insufficient.
- There are no signatures and no evidence of medical necessity in the progress notes.
- There were no discharge criteria in the treatment plan and no evidence of progress towards goals in the progress notes.

Baseline Review Summary

Determinations of the following critical areas of review are:

- Billing for Services not rendered or not provided as claimed – There is no evidence this is occurring
- Submitting claims for services that are not reasonable and/or necessary – The documentation does not support reasonableness or medical necessity
- Double billing resulting in duplicate payments – There is no evidence that double billing has occurred
- Billing for non-covered services as if covered – There is no evidence that this has occurred.
- Knowing misuse of provider numbers that result in improper billing – This could not be assessed
- Incomplete or illegible medical records – Documentation was legible in the majority of cases. Completeness was lacking most notably in the area of required signatures.
- Lack of documentation for medical necessity – This was clearly an area of great concern. Medical necessity was not evident in the majority of records reviewed.

Recommended Action Plan

An orientation and training program should be developed and implemented to address documentation issues. This program would focus on:

Weeks 1-3

- Form design review – treatment plan, progress note, 90 day reviews
- Education on rationale for required documentation standards
- Orientation materials
- Ongoing training material development
- Compliance measurements and tools
- 'Train the trainer' workshop information and tools
- Training and criteria development for UR staff
- Tickler system for timely submission of required documents
- Develop Compliance Plan

Weeks 4-6

- On-site training of identified Any Agency staff
- Completion of orientation and training materials for ongoing use at Any Agency
- On-site training of UR staff to occur following clinician documentation didactics

Ongoing

- Follow up chart review in 3 months to assess compliance
- Follow up training sessions as needed