SECTION – ADMINISTRATION
ADMINISTRATIVE DIRECTIVE NO. 142
(Replaces A.D. No. 142 dated 6/15/06)

Effective Date: June 14, 2007

SUBJECT: COMPLIANCE PLAN – MEDICARE PART B: MEDICAL RECORDS DOCUMENTATION, BILLING & CODING

I. PURPOSE

This Administrative Directive documents the Compliance Plan in place at Coalinga State Hospital (CSH). Inasmuch as CSH participates in Medicare Part B Billing (Fee-For-Service), the facility is required to have a Compliance Plan that supports appropriate documentation, coding, and billing practices as directed by Federal, State, and Department of Mental Health policies. It is intended that this Compliance Plan provide guidance for the legal processing of billable services that are accurate, reliable, and reflect the integrity of CSH.

II. AUTHORITY

Federal False Claims Act (FCA), 31 USC 3729; Health Insurance Portability and Accountability Act (HIPAA) of August 21, 1996; Balanced Budget Act of 1997 (BBA); Department of Health and Human Services (DHHS); Office of Inspector General (OIG); and Office of the Inspector General Workplan of 1998.

III. POLICY

CSH will administer a Compliance Plan that is designed to ensure that the hospital is providing and billing for services according to the laws, regulations, and guidelines that govern it.

A. Healthcare providers participating in Medicare Part B billing are responsible for:

1. Maintaining a current knowledge of and compliance with all related requirements.

2. Complying with all laws, regulations and standards governing billable services.

3. Providing accurate and timely documentation and medical information that support billable services.

4. Reporting violations of this policy to their respective supervisor.

Monitoring systems shall be in place in all hospital areas that participate in medical record documentation, coding and billing for the purpose of identifying, investigating, and preventing violations related to the delivery and payment for healthcare services.

IV. METHOD

All medical record documentation and billing processes occurring after July 1, 1999, will be subject to the policies and procedures described in this Compliance Plan.

A. Description of Procedures:

The procedures described in this section shall be followed by health care providers and ancillary services responsible for documenting or otherwise processing billable services for Part B Medicare Individuals.

1. Health Care Provider:

a. In all cases, whether Medicare-eligible or not, the Individual's medical record must contain appropriate and necessary documentation concerning the services provided. Required medical record components include documentation of ordered services, including information supporting the medical necessity of those services, the Individual's diagnoses, and documentation of the services actually provided by the health care provider. Proper and timely documentation concerning Individual status and services provided are required. Each time a health care provider administers care to an Individual, he/she is instructed to fully document the care rendered in the Physician Progress Notes (PPNs).

b. Notes must include:

i. Date and time Individual was seen, indication that an Individual was seen face to face. The CPT4 code(s) will be selected by the clinician indicating the type of encounter. Focus numbers corresponding to the Wellness and Recovery Plan are also required for each documentation.

ii. All entries will be done in "SOAPE" format; Subjective, Objective, Assessment, Plan, Education. All elements will be addressed.

iii. Each entry should document all pertinent information: reason for the encounter; relevant history; exam findings; assessment; clinical impression or diagnosis; and a plan of care.

iv. The rationale for ordering diagnostic and/or other ancillary services should be spelled out.

v. Appropriate health-risk factors should be identified.

vi. The Individual's progress, response and changes in treatment, and any revisions in diagnoses, should be documented.

vii. All entries must be legible and signed.

viii. Carbon copies of the PPNs are routed to the Health Information Management Department (HIMD) for processing.

B. Hospital Trust Office:

1. Inquiries will be initiated after Individual admission to determine if the Individual is eligible for Medicare benefits.

2. The HIMD will be notified of Individuals identified as "Medicare Eligible".

C. HIMD:

1. Only accurate and properly documented services will be billed. HIMD staff members will query the health care provider to obtain clarification on billing documentation when indicated.

2. All billing will be done so as to reflect current coding regulations and procedures.

3. Internal audits, regardless of payor, will be performed and reported on a regular and periodic basis to determine if codes reported on PPNs are supported by the medical record documentation.

V. EDUCATION AND TRAINING

A. Health Care Providers:

1. Basic instruction on Medicare reimbursement documentation will be provided. This educational component will include information about fraud and abuse laws, Medicare reimbursement principles, health care documentation practices, billing, diagnostic and treatment codes, and potential problem areas identified through assessments.

2. Every Health Care Provider will be required to attend initial training during the first 2 weeks on duty. Refresher training is required annually and will be provided as requested by staff. Attendance records will be kept of such training.

3. Providers will attend, as directed, education and training sessions sponsored by DMH Headquarters and/or the Medicare carrier (National Heritage Insurance Company – NHIC).

B. HIMD Staff; Trust Office Staff; Others Employees as Necessary:

Department orientation will include Compliance Plan training. This component will be comprehensive, and will include information about fraud and abuse laws, Medicare reimbursement principles, health care documentation, billing, coding, and potential problem areas identified through assessments. Individuals will participate in training sessions when assigned to do so. Individuals with responsibility for coding (ICD-9-CM, CPT) will be provided with ongoing education and resources necessary to competently perform these duties. Coding resources are to remain current and available to users. Individuals with responsibility for coding will keep abreast of ICD-9-CM and CPT coding changes and updates. The individual departments will maintain department orientation records, course outlines, course content, and sign-in sheets.

VI. AUDITING AND MONITORING

A. HIMD is responsible for conducting and reporting on Medicare and non-Medicare documentation audits on a quarterly basis to the Medical Records Committee.

B. Audits will be conducted for the purpose of comparing documentation to selected CPT4 numbers. Compliance with documentation rules (e.g., signatures, dates, exam documentation) will be evaluated. Sample size will be developed to incorporate cases from all health care providers who document and bill for services.

C. Conflict of Standards: Whenever any of the Medicare documentation standards vary from those standards described elsewhere, the applicable standard shall be the one that is most comprehensive.

D. Findings of all HIMD studies and audits will be reported to the Medical Record Committee or as directed. After initial Committee review, findings will be transmitted to designated disciplines: Executive Director, Hospital Administrator, Medical Director, Clinical Administrator, department heads, and program directors.

E. The success of the Compliance Plan will be assessed no less than annually to determine if areas of potential risk have been identified, if problem areas have been addressed, if actions have been taken, and if staff education has occurred. Appropriate records will be made and maintained to document the effectiveness of compliance.

VII. PROBLEM IDENTIFICATION AND RESOLUTION

A. Problems and/or concerns identified through the audit process will be reported through the committee structure.

B. Problem resolution will include comprehensive educational components. Training and individual assistance will be provided to staff as appropriate.

C. Noncompliant staff will be subject to informal and formal counseling. Disciplinary actions will be taken if deemed warranted.

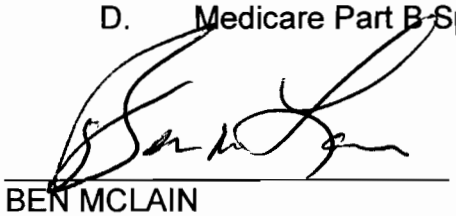
VIII. RESOURCES

A. State Department of Mental Health

B. State Department of Developmental Services

C. National Heritage Insurance Company (NHIC), Educational Outreach

D. Medicare Part B Special Notices



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