Encounter Data Validation

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Why EDV?

- Encounter data are the electronic records of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers are paid), when the services would traditionally be a billable service under fee-for-service (FFS) reimbursement systems.

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/eqr-protocol-4.pdf

Why EDV?

- The State uses encounter data to assess and improve quality, monitor program integrity and determine capitation rates.
- EDV is required as a part of the State's contract with RSNs/BHOs.

Data Certification and Contract

- **Data Certification**. The Contractor must comply with the required format provided in the Encounter Data Transaction Guide published by DSHS. Data includes encounters documenting services paid for by the Contractor and delivered to Individuals through the Contractor during a specified reporting period as well as other data per the Data Dictionary and Service Encounter Reporting Instructions (SERI). This data is used for Federal reporting (42 CFR 438.242[b] [1]), rate setting and risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care, DSHS hospital rate setting and research studies.

BHO PIHP contract

Certifications and Program Integrity

- § 438.604 Data that must be certified.

  (a) Data certifications. When State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP, the State must require certification of the data as provided in § 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data and other information required by the State and contained in contracts, proposals and related documents.

Certifications and Program Integrity, cont.

(b) Additional certifications. Certification is required, as provided in § 438.606, for all documents specified by the State.

Scoring criteria:

- The BHO has policies and procedures in place to ensure data submitted to the State are certified.
- The BHO has documented mechanisms in place to comply with the applicable certification, program integrity and prohibited affiliation requirements of this subpart.

Certifications and Program Integrity, cont.

- The BHO has mechanisms in place to ensure data submitted as part of § 438.606 (including, but not limited to, enrollment information, encounter data and other information required by the State and contained in contracts, proposals and related documents) are certified.
- The BHO performs data integrity checks on certified data submitted to the State.
- The BHO monitors data submitted by its subcontractors, providers and vendors.

Certifications and Program Integrity, cont.

(a) Source of certification. For the data specified in § 438.604, the data the MCO or PIHP submits to the State must be certified by one of the following:

(1) The MCO's or PIHP's chief executive officer.

(2) The MCO's or PIHP's chief financial officer.

(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's chief executive officer or chief financial officer.

Certifications and Program Integrity, cont.

(b) Content of certification. The certification must attest, based on best knowledge, information and belief, as follows:

(1) to the accuracy, completeness and truthfulness of the data

(2) to the accuracy, completeness and truthfulness of the documents specified by the State

(c) Timing of certification. The MCO or PIHP must submit the certification concurrently with the certified data.

Certifications and Program Integrity, cont.

Scoring criteria:

- The BHO has mechanisms in place to ensure the data the BHO submits to the State is certified by one of the following:

  (1) the BHO's chief executive officer

  (2) the BHO's chief financial officer

  (3) an individual who has delegated authority to sign for, and who reports directly to, the BHO's chief executive officer or chief financial officer

Certifications and Program Integrity, cont.

- The BHO has mechanisms in place to ensure the content certification attestation indicates, based on best knowledge, information and belief, as follows:

  (1) the accuracy, completeness and truthfulness of the data

  (2) the accuracy, completeness and truthfulness of the documents specified by the State

- The BHO has mechanisms in place to ensure the BHO is submitting the certification concurrently with the certified data.

Claim vs. Encounter

Claim: A request for payment that is submitted when an individual receives services that are covered.

Encounter: A contact between an individual and a provider who is responsible for diagnosing and treating the individual.

Elements Reviewed by Contract

- Date of service
- Name of service provider
- Provider type
- Minutes of service
- Service location
- Procedure code
- Service code agrees with treatment described

Required Elements in the Service Encounter Reporting Instructions (SERI)

Clinical entries must include:

- author identification (which may be a handwritten signature or unique electronic identifier)
- date of service
- location of service
- provider credentials (which must be appropriate to the service)
- length of time

Required Elements in SERI, cont.

- narrative description of the service provided as evidenced by sufficient documentation that can be translated to a service description title or code number (this may be standard CPT/HCPCS or local nomenclature with an RSN/BHO-approved crosswalk) and describes therapeutic content

https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information

Documentation Requirements

The documentation must, according to the State's Medicaid program rules:

- to the extent required under State law, reflect medical necessity and justify the treatment and clinical rationale (remember, each State adopts its own medical necessity definition)
- to the extent required under State law, reflect active treatment

and

- be complete, concise and accurate, including the face-to-face time spent with the patient (for example, the time spent to complete a psychosocial assessment, a treatment plan or a discharge plan)

Documentation Requirements, cont.

- be legible, signed and dated
- be maintained and available for review
- be coded correctly for billing purposes

"There are some things to avoid as a behavioral health practitioner. Never bill chance, momentary social encounters between a therapist and a patient as valid therapeutic sessions, never bill undocumented services, and never bill services coded at a higher level than those furnished."

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf

OIG Report

- Fifty-five percent of claims for E/M services were incorrectly coded and/or lacking documentation in 2010, resulting in $6.7 billion in improper Medicare payments.
- The amount for 2014 significantly increased.

http://oig.hhs.gov/oei/reports/oei-04-10-00181.pdf

CMS

Medicaid improper payments were primarily due to provider documentation: Most Medicaid projected improper payments resulted from providers failing to submit the necessary documentation to support the claim.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2013MedicaidandCHIPImproperPaymentsReport.pdf

CMS References

https://www.youtube.com/watch?v=WOrAvj-9LTI&feature=youtu.be

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html

Date of Service

- Review that the service was provided on the date reported.
- Best practice: Also review the date that the progress note was written and signed.

Date of Service, cont.

WAC 388-877A-0120 Outpatient mental health services—Clinical record content and documentation.

- Progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type, or provide documentation as to why this did not occur.

Name of Service Provider

- Ensure that the name of the service provider matches what was submitted, if using your own data and not ProviderOne data.
- Ensure that if there was a name change that it was updated in a timely manner.
- Initials are not acceptable.
- If signed by hand, the name should also be printed to ensure legibility.

Common Issues with Name of Service Provider

- Clinician marries and/or changes name.
- Signature is illegible.
- Clinician signs with initials only.
- No identifying information is contained in the documentation.

What Does SERI Say?

General encounter reporting instructions:

- The record must be legible to someone other than the writer.
- Clinical entries must include:
  - author identification, which may be a handwritten signature or unique electronic identifier.

SERI Also Says…

- Provider credentials must be appropriate to the service; e.g, medication management can only be performed by a prescriber.

Provider Type

- Ensure that the provider type matches the clinician's signature.
- If there was a change in provider type, verify that this was updated in a timely manner.
- Ensure that the provider type is allowable for the submitted code within the SERI.

Common Issues with Provider Type

- Provider type is not allowable with the code used, per the SERI.
- Clinician graduated with a bachelor's or master's degree and the provider type was not updated in MIS.
- Staff was assigned the incorrect provider type (example: administrative staff assigned a clinical provider type)

Minutes of Service

- Validate that the minutes of service that were submitted match what is on the progress note.
- Ensure that there are no non-encounterable services contained within the documentation or included in the total duration submitted.

Minutes of Service, cont.

- If using State data, verify that services were submitted using the correct corresponding minutes or units.
- Ensure that the code is the correct code for that duration.

Common Issues with Duration

- Code was submitted with units when it should have been minutes.
- Code was submitted with minutes when it should have been units.
- Bundled services included non-encounterable services.
- Wrong code was used for duration submitted (e.g., 90837 for 90-min. service).

Service Location

- Ensure the location matches the location submitted.
- Ensure that the location submitted matches what the documentation states.
- Ensure that the provider-RSN/BHO crosswalk is accurate.

Definitions of service location can be found at

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html .

Common Issues with Location

- Crosswalk did not match (e.g., provider submitted 53 to RSN; RSN submitted 11 to ProviderOne).
- Location was submitted one way, but the documentation supported something different.

Procedure Code

- Ensure that the procedure codes match.
- Other information in the prior slides will also assist in determining whether or not this is the correct code.

Service Code Agrees with Treatment Described

- Does the documentation contain a clinical intervention and therapeutic content?
- Does the documentation support an encounterable service?
- Does the documentation support the code that is used?

Bundling

- Bundling is reporting multiple encounters occurring on the same day for the same enrollee when the encounters occur at different times.
- With the exception noted below, do not roll up multiple encounters.
- Each service encounter must have a progress note that meets all CMS requirements.

Bundling, cont.

- Exception: If the same service is provided discontinuously to a particular enrollee on a particular day by the same provider and was provided for less than the minimum time defined by the procedure/service code, the provider can roll up the minutes to a single service and report that number of units.
- Documentation in the client record must record these separate events and meet documentation requirements noted below.

Cloning Notes

Cloning:

- This practice involves copying and pasting previously recorded information from a prior note into a new note.
- The medical record must contain documentation showing the differences and the needs of the enrollee for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable.

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf

Non-encounterable Services

- texting
- reading or writing emails
- listening to or leaving voicemail
- transportation
- playing board games or sports
- scheduling appointments
- faxing
- calling in rx refills
- shopping
- internal consultation, staffing or communication

More Non-encounterable Services

- filling med packs without client present
- reminder calls
- payee services without the client present
- fishing
- socialization
- going to skate park or state park
- eating lunch
- taking out the trash

Top Ten Common Healthcare Provider Fraud Schemes

- billing for services not rendered
- billing for a non-covered service as a covered service
- misrepresenting dates of service
- misrepresenting locations of service
- misrepresenting provider of service

Top Ten, cont.

- waiving deductibles and/or co-payments
- incorrectly reporting diagnoses or procedures (including unbundling)
- overutilization of services
- corruption (kickbacks and bribery)
- falsely or unnecessarily issuing prescription drugs

http://www.fraud-magazine.com/article.aspx?id=4294976280

Questions

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