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Search for Compliance Documentation Requirements Part 2: Progress Notes and Encounter Forms

Melissa S. Hooks
Director of Program Integrity



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Overview of Presentation

- Background of Compliance
- Importance of Documentation
- Overview of Documentation Requirements: Two Part Series

- Part 2: Documentation Requirement Topics
 - Progress Notes
 - Encounter Forms



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Background of Compliance



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Why Compliance All the Time?

- **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

Compliance Definitions

- **FRAUD**

- Any intentional deception or misrepresentation made by an entity or person in a capitated MCO, Primary Care Case Management, or other managed care setting with the knowledge that the deception could result in an unauthorized benefit to the entity, him/herself or another responsible person in a managed care setting.

Compliance Definitions

▪ ABUSE

- Any practices in a capitated MCO, Primary Care Case Management program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practice and which result in unnecessary cost to the MA Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the PA HC PSR, contracts, and requirements of state or federal regulations) for health care in the managed care setting.

Compliance Definitions

- **WASTE**

- Thoughtless or careless expenditure, consumption, mismanagement, use or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems or controls.

Compliance Requirements for FWA

- **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



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Importance of Documentation



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Importance of Documentation

CMS reports, "Keeping accurate medical records on every patient and safeguarding those records are important responsibilities health care professionals can provide for one another. Well-documented medical records frame the background for a patient's current and future care. More importantly, medical health records are legal business records. They must be maintained following federal and state regulations to ensure that the information, if accessed, is accurate and complete."

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLN_Podcast_Medical_Record_Retention_and_Media_Format.pdf

Importance of Documentation

- **Documentation – Just as Important as the Service:**
 - The ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time
 - Communication and continuity of care among the physicians and other healthcare professionals involved in the patient care
 - Accurate and timely claims review and payment
 - Appropriate utilization review and quality of care evaluations
 - Collection of data that may be used for research and education
 - Evidence that the services were provided

Importance of Documentation

- **Important Considerations for Documentation:**
 - Timely
 - Respectful
 - Complete
 - Credible
 - Clear
 - Consistent
 - Integrity

http://www.vbh-pa.com/provider/info/value_archives/2014/VA-Aug-2014.pdf

Importance of Documentation

“Record-keeping is often thought of as a distraction from the direct work that happens with clients. However, when it comes to good clinical practice, documentation is an important part of the process that requires clinicians to follow key ethical considerations.”

By Chris Rich, LSW, ACSW, - National Association of Social Workers - PA Chapter
http://www.vbh-pa.com/provider/info/value_archives/2014/VA-Aug-2014.pdf



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Overview of Documentation Requirements

Two Part Series



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Program Integrity Documentation Requirements

- Outline regulations for treatment and service documentation
- Review the documentation requirements to receive payment from VBH-PA
- Provide specific documentation requirements

Program Integrity Documentation Requirements

- **Part 1**
 - **Consent Forms**
 - Regulations
 - Minimum Documentation Requirements
 - Potential Findings
 - **Treatment Plans**
 - Regulations
 - Clinical Requirements
 - Minimum Documentation Requirements
 - Potential Findings

Program Integrity Documentation Requirements

- **Part 2**
 - **Progress Notes**
 - Regulations
 - Clinical Requirements
 - Minimum Documentation Requirements
 - Potential Findings
 - **Encounter Forms**
 - Regulations
 - Minimum Documentation Requirements
 - Potential Findings



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Progress Notes



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Progress Notes

- **Main Purpose of Progress Notes**

1. Document progress at each visit, change in diagnosis, change in treatment and response to treatment
2. Document medical necessity and justification for payment from Medical Assistance

PA Regulations for Progress Notes

- **Pennsylvania Code**

- Chapter 1101 General Provisions

- <http://www.pacode.com/secure/data/055/chapter1101/chap1101toc.html>
- §1101.51. Ongoing responsibilities of providers.
 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.

PA Regulations for Progress Notes

- **Pennsylvania Code**

- Chapter 1101 General Provisions

- 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.

PA Regulations for Progress Notes

- **Pennsylvania Code**

- Chapter 1101 General Provisions

- 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.

PA Regulations for Progress Notes

- **Pennsylvania Code**

- Chapter 5100 Mental Health Procedures

- <http://www.pacode.com/secure/data/055/chapter5100/chap5100toc.html>

- § 5100.15. Contents of treatment plan.

- a) A comprehensive individualized plan of treatment shall:

- 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.

PA Regulations for Progress Notes

- **Pennsylvania Code**

- Chapter 5200 Psychiatric Outpatient Clinics

- <http://www.pacode.com/secure/data/055/chapter5200/chap5200toc.html>

- § 5200.41. Records.

- a) Under section 602 of the Mental Health and Mental Retardation Act of 1966 (50 P. S. § 4602), and in accordance with recognized and acceptable principles of patient record keeping, the facility shall maintain a record for each person admitted to a psychiatric clinic. The record shall include the following:

- 8) Treatment progress notes for each contact.

PA Regulations for Progress Notes

- **Pennsylvania Medical Assistance Bulletin**
 - Documentation and Medical Record Keeping Requirements (2002)
 - 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 individual(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.

VBH-PA Requirements for Progress Notes

■ VBH-PA Provider Manual

- Treatment Records
 - http://www.vbh-pa.com/provider/info/prvmanual/4_PartPrvResp/tx_record_standards.htm
 - Participating providers are expected to maintain clinical record keeping systems that meet the following basic requirements:
 - 5) All members' treatment records must contain a bio-psychosocial assessment; treatment plan, follow-up assessments, focus of treatment and disposition/discharge plan. Medical and psychological treatment documentation and progress notes must be current and treatment plans shall be updated as necessary for the level of care.

Minimum Documentation for Progress Notes

- **VBH-PA Requirements for All Providers**

<http://www.vbh-pa.com/fraud/pdfs/Minimum-Provider-Documentation-Standards-for-Payment.pdf>

- I. In addition to VBH-PA requirements in this section and in the VBH-PA Provider Manual, all providers are responsible to follow all requirements under Pennsylvania Medical Assistance regulations, publications, and bulletins.
- II. All providers must have member charts that include all requirements as defined in the Pennsylvania Code Provider Responsibilities regulations and VBH-PA Provider Manual to support the claims billed.
- III. All documentation must meet the requirements of the service codes that are submitted on the claims form.
- IV. All requirements for documentation must be completed prior to the claim form submission date.
- V. All requirements must be legible.

Minimum Documentation for Progress Notes

- **VBH-PA Requirements for All Providers**

- VI. All encounters must have a progress note to support the service billed.
- VII. All direct encounters must have an encounter form to verify services.
- VIII. All amendments or changes to the documentation must be signed and dated by the clinician amending or changing the documentation.
- IX. Training related to documentation standards is located at: http://www.vbh-pa.com/provider/prv_trn.htm

Minimum Documentation for Progress Notes

- **VBH-PA Requirements for All Providers**

- X. All providers must have the following minimum documentation for treatment plans, encounter forms, and progress notes to receive payment for claims billed:

- C. Progress Note: Minimum Requirements for Payment for all Provider Types:

- 1. Must be completed for each billable encounter
 - 2. Name or Medical Assistance identification number
 - 3. Date of service
 - 4. Start and stop times of service
 - 5. Units match the claims billing
 - 6. Place of service (specific location for community services)

Minimum Documentation for Progress Notes

- **VBH-PA Requirements for All Providers**

- X. All providers must have the following minimum documentation for treatment plans, encounter forms, and progress notes to receive payment for claims billed:

- C. Progress Note: Minimum Requirements for Payment for all Provider Types:

- 7. Reason for the session or encounter
 - 8. Treatment goals addressed
 - 9. Current symptoms and behaviors
 - 10. Interventions and response to treatment
 - 11. Next steps and progress in treatment
 - 12. Narrative with the clinical justification to support utilization and time billed
 - 13. Supporting documentation, when applicable
 - 14. Clinician's signature, credentials, and signature date

Progress Notes Findings

■ VBH-PA Program Integrity Potential Findings

- Progress notes do not support medical necessity or the time billed:
 - Pennsylvania Code and regulations specifically state that providers must fully disclose and describe the services that are billed under Medical Assistance:
 - The record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment
 - The progress note must specify services rendered
 - The progress note must support medical necessity and justify the time billed
 - The treatment plan should define the utilization and support the medical necessity for the frequency and length of service
 - Then the progress note should fully disclose the service provided

Progress Notes Findings

- **VBH-PA Program Integrity Potential Findings**
 - Non-billable service documented in progress notes
 - Case management, central intake or records, training, administration, social rehabilitation, program evaluation or research
 - Travel and transportation
 - Cancelled appointments
 - Clinic service provided over the telephone
 - Please note that documenting non-billable services is still necessary but can not be submitted for payment

Progress Notes Findings

▪ VBH-PA Program Integrity Potential Findings

- VBH-PA Audit Exceptions

<http://www.vbh-pa.com/fraud/pdfs/Program-Integrity-Exceptions-and-Findings.pdf>

- No progress note
- No services were rendered (no shows)
- No narrative
- Progress note is illegible
- Inaccurate units billed
- Progress note does not provide specific location
- Progress note does not have start and stop times

Progress Notes Findings

- **VBH-PA Program Integrity Potential Findings**
 - VBH-PA Audit Exceptions
 - Rounding units
 - Exception case management and resource coordination
 - Services were unbundled and billed individually
 - This applies when services are paid by events or per diems
 - Examples: crisis diversion and methadone maintenance
 - Services are bundled
 - This applies when services are paid by units of time
 - Examples: BHRS or case management

Progress Notes Findings

- **VBH-PA Program Integrity Potential Findings**
 - VBH-PA Audit Exceptions
 - Correction to note is not initialed and/or dated
 - In 2015, this could result in identified overpayment
 - Progress note details (service code, units, time) do not match encounter form or claim
 - Incorrect service code or modifier billed
 - Progress note is not signed and/or dated by clinician

Progress Notes Findings

■ VBH-PA Program Integrity Potential Findings

- VBH-PA Clinical Audit Exceptions

<http://www.vbh-pa.com/fraud/pdfs/Program-Integrity-Exceptions-and-Findings.pdf>

- Progress note does not state reason for the encounter
- Progress note does not state treatment plan goals and objectives
- Progress note does not reference symptoms or behaviors
- Progress note does not have next steps in treatment
- Progress note does not state intervention
- Progress note or narrative is a duplication or almost a duplication of previous note or narrative
- Supporting documentation was not attached, when required
 - Example: BHRS

Progress Notes Tips

■ Progress Note Clinical Tips

- Leave enough room for a narrative that will fully describe the services provided
- In the narrative, explain the frequency, length, location, intervention in relation to treatment plan and medical necessity to justify the payment from Medical Assistance
- Location of service should be justified in treatment plan and fully described in progress note
- Treatment goals and objectives can be listed but the narrative should describe the goals and objectives in terms of progress and the interventions utilized
- Fully describing the next steps in treatment will justify your necessity for continued services

Examples of Progress Notes

▪ **Acceptable Types of Progress Notes**

- VBH-PA does not endorse a specific format or type of progress note
- VBH-PA reminds providers that templates do not meet the requirements, the content of the progress note (template) will meet the requirements
 - Templates and forms should be used as guides

Examples of Progress Notes

▪ SOAP Notes

- Developed in 1970 and one of the most common formats
 - Subjective Component
 - Describes the patient's current condition in narrative form
 - Objective Component
 - Documents objective, repeatable, and traceable facts about the patient's status
 - Assessment
 - Documents symptoms, behaviors, and diagnoses for the date of the session
 - Plan
 - Describes the interventions and next step in treatment

Examples of Progress Notes

▪ APSO Notes

- Created for EMRs and changes the order of documentation
- Easier to follow treatment and progress
- Guides documentation to be more patient-centered by reviewing the patient information first
 - Assessment
 - Plan
 - Subjective Component
 - Objective Component
 - Enhanced to include all regulatory and billing requirements



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Encounter Forms



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Encounter Forms

- **Encounter Form**

1. Verify services were provided
 - Encounter form must be signed after the session
2. Meet the Federal regulations for Medicaid programs
 - 42 CFR – Public Health www.gpo.gov
 - 455.20 Recipient verification procedure
 - a) The agency must have a method for verifying with recipients whether services billed by providers were received

PA Regulations for Encounter Forms

- **Pennsylvania Bulletins**

- PA Medical Assistance Bulletin #99-89-05

- The Department's policy has always been that medical assistance invoices must have either the recipient's signature or the words "signature exception" appearing in the signature field. The signature certifies that the recipient received a medical service or item that the recipient listed on the Medical Service Eligibility Card is the individual who received the service.

PA Regulations for Encounter Forms

- **Pennsylvania Bulletins**

- PA Medicaid Bulletin# 99-03-021, Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Sets Updates, December 2003
 - Providers who bill via continuous-print claim forms (pin fed) or electronic media must retain the recipient's signature on file using the Encounter Form. The purpose of the recipient's signature is to certify that the recipient received the service from the provider indicated on the claim form, and that the recipient listed on the Pennsylvania ACCESS Card is the individual who received the service.

VBH-PA Requirements for Encounter Forms

▪ VBH-PA Fraud and Abuse Webpage

- Minimum Documentation Standards for Payment:

<http://www.vbh-pa.com/fraud/pdfs/Minimum-Provider-Documentation-Standards-for-Payment.pdf>

- B. Encounter Form: Minimum Requirements for Payment for all Provider Types:

1. Must be completed for each billable encounter (except for services that are excluded from encounter form requirements)
2. Member name including member identification number (as required in the PA Medicaid Bulletin)
3. Type of service
4. Date with start and stop times
5. Total units billed
6. Signature of Member for each encounter
7. Clinician's signature, credentials, and signature date

Encounter Form Findings

▪ VBH-PA Fraud and Abuse Webpage

- Common Audit Exceptions and Findings

<http://www.vbh-pa.com/fraud/pdfs/Program-Integrity-Exceptions-and-Findings.pdf>

- No encounter form
- Encounter form is not signed by member, parent, guardian, or agent
- Encounter form does not include start and stop times
- Encounter form does not include type of service
- Encounter form not signed by clinician
- Correction to encounter form is not initialed and/or dated
- Encounter form details (service code, units, time) do not match progress note or claim

Encounter Form Tips and Reminders

▪ Encounter Form Tips and Reminders

- Encounter forms must be signed after the session to meet the requirements
- Encounter forms must be signed for all sessions to bill Medical Assistance
- Members should NEVER be asked to sign blank encounter forms or sign prior to services being provided
 - DPW considers this to be FRAUD
- VBH-PA sends member verification surveys and plans to send explanation of benefits (EOB)
- VBH-PA Training specific to member verification and encounter forms: http://www.vbh-pa.com/fraud/pdfs/Part-III_Search_for_Compliance.pdf

Encounter Form Examples

▪ Types of Encounter Forms

- VBH-PA does not endorse a specific encounter form template. The encounter form must meet minimum documentation standards.
- VBH-PA accepts the following different formats:
 - Individual encounter form (Outpatient)
 - Multiple session on encounter form in table format (BHRS and Case Management)
 - Encounter form embedded within the progress note (EMRs)