Legislation Text

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LCHD/CHC Corporate Compliance Report Jan-Jun2008 - Schanding

Corporate compliance-first half 2008

In 2007 you approved the Health Department's Corporate Compliance Plan. The Corporate Compliance Plan, focusing particularly on billing practices, is a requirement for organizations that receive $5 million in Medicaid funds annually. The plan's adoption included providing feedback to the Board of Health twice annually on the results of internal audits completed to monitor billing practices.

Listed below are the findings of the most recent reviews of the three service areas that generate Medicaid billings:

Community Health Services

Four programs bill Medicare or Medicaid for services provided. Three of the programs (Immunizations, Tuberculosis Clinic, and Hearing and Vision) generate bills for services directly from the encounter forms that are completed at the time of service. Billing is generated from the encounter forms and totals are double checked for accuracy prior to submission. In effect, audits are conducted concurrently.

Family Case Management generates bills based on services documented in the client's record. An audit of one bill for each Case Manager is conducted monthly to assure that the service being billed is adequately documented. The number of correctly documented bills for service is presented below.

CHN Billing Audit Totals 2008 Jan-Jun		
Month	Number of Audits	Errors
January-08	15	1. Denver no line, signat
February-08	15	1. Incorrect birthdate
March-08	9	
April-08	13	
May-08	12	
June-08	10	
Total	74	2

There were 2 deficiencies identified in an audit of 74 case manager charts. A description of the two errors is included in the table above.

Errors or inaccuracies are returned to the nurse for correction. The correction is rechecked, and the bills are

submitted once the corrections are completed.

Primary Care Services

Data Entry Review

Patient encounter process remained the same for the quarter. Each encounter is initiated once intake of the patient has been completed. Each encounter is given a unique identifier, which is printed on a label and attached to a billing sheet. Clinical staff is responsible for documenting services onto the billing sheet which reflects a service provided to the patient. Data entry of billing sheets is completed by Patient Care Representatives (PCR's). Billing sheets are then sent to the Billing Office where data entry is verified against daily error and data entry reports. Goal is to maintain a 95% accuracy rate system wide. Any encounter with an error is corrected prior to any billing to a third party or the patient. Current review results show Medical at 96% and Dental at 96%.

Encounter Entry

Missing encounter reports are run on a daily basis to ensure data entry completion. A goal has been set that 95% of all encounters will be entered within a 24 hour period. All encounters are accounted for and billed. Current review results show Medical at 71% for the first quarter and 64% for the second quarter and Dental at 99% for both quarters for encounter entered within 24 hours. All encounters are required to be entered within 5 days of the end of month. Current quarter review results show Medical at 99% and Dental at 99%.

Third Party Billing

Prior to billing of insurance claims, additional monthly error and edit reports are run to catch claim errors. Commercial insurance claims are sent by paper and seldom rejected for anything other than birth control medication codes. Commercial insurance non-payment is generally due to deductible or out-of-network reasons. Re-billing of all rejected claims is done upon receipt of Explanation of Benefit (EOB). The current third quarter review indicated we had no rejected claims.

Medicare and Medicaid claims are sent electronically. Average rejection rate during the past year was less than 8%. Current results for the Medicaid was at 0% and Medicare was at 7%. These claims were corrected and resubmitted for payment.

Sliding Fee Audit

During the first quarter, 3070 medical and 456 dental applications were reviewed. The goal in each medical and dental site is for at least a 90% accuracy rate. During the 1st quarter review Medical was at 94.1% and Dental was at 84.6%. During the 2nd quarter review Medical was at 95.4% and Dental was at 84.9%. All errors have been corrected in the patient management system so all account reflect the correct discount. Action Item- Staff members from the Belvidere Dental Clinic were retrained on March 28th. The over-all percentage has stayed relatively the same from the 1st quarter to the 2nd quarter at 76.6.5% and 79.7% respectively. For the 3rd quarter staff that is below 90% will be give a verbal warning. If they are still below the 90% for the 4th quarter a written plan of actions will be given to each staff person. Staff the North Chicago Dental Clinic had a 100% turn over. This staff was trained on July 3rd and there percentage has increased to 91% after 1 month.

Medical Chart Review

During this first half of 2008 a modified audit was performed by the Health Information Manager. The results were reviewed with the Medical Director and Associate Director. The goal for the Audit is 100% compliance.

The first quarter audit results show us at 65%. 20 charts were reviewed. Of those chart reviews 2 showed codes used that were above what data was documented in the chart and 4 showed codes used that were below what was documented in the chart. All billings were corrected as needed by payor.

During the second quarter, results show us at 80%. 20 charts were reviewed. Of those chart reviews 2 showed codes used that were above what data was documented in the chart and 2 showed codes used that were below what was documented in the chart and 1 had an incorrect age group code. All billings were corrected by payor as needed.

Action Plan

In response to the audit process and findings the following actions have been put into place:
The search to fill the Medical Coding Specialist will resume with intent of hire prior to fourth quarter close. The chart review process will be modified to provide a small sampling of records being reviewed on a weekly basis. Charts will continue to be reviewed with the Medical Director, after which the Health Information Manager will meet with the selected providers to discuss their visit E/M coding, documentation and additional details provided by the Medical Director. The Medical Director will also discuss any issues with the provider at next clinic visit.

To facilitate the update and education process, the Health Information Manager will present an overview of visit documentation in association with E/M coding at the September Professional Staff meeting for all providers. The Health Information Manager will also place current E/M coding information on the agency common drive to facilitate easy reference access for the providers. The Medical Director will personally discuss any issues or suggestions with the select providers at his next clinic visit or scheduled meeting. The Medical Director will also provide a brief orientation to documentation and coding to all new permanent providers. Upon hire of the Coding Specialist, a more detailed orientation and on-going education plan will resume.

Behavioral Health Services

There were no changes in the billing processes during the first half of 2008. Each billable service provided required a progress note that included the patient name, identification number, provider of service, type of service, date, time of day, and duration of service. Billing information is entered by support staff into the practice management system. These staff print a summary of progress notes entered on a daily basis to check for data entry errors. Data staff continued to run billing information through a series of computer software edits to catch any errors, including duplicates, service overlaps, and improper credentials. Overall, the goal is to be under 1% error rates. In Q1 2008, there were 47,206 billable visits processed. In Q2 2008, there were 47,206 billable visits processed. In both quarters, the error rate remained under 1%. The most common reason for voiding and rebilling was wrong date.

Quarterly progress note audits were completed to assure that services billed match documentation of services provided. . The audit included 2539 bills reviews in quarter one and 3261 bill reviews in quarter two. The audits finding showed an increase in missing progress notes across the agency from 2% in 4th quarter 2007 to 5% in 1st quarter 2008. This increase was due to a few programs which fell behind in the filing of progress notes. Second quarter audits finding showed a decrease in missing progress notes across the agency from 5% in 1st quarter to 2% in 2nd quarter 2008. All progress notes were located and filed in the appropriate chart. The data entry errors decreased from 1.5% in Q4 2007 to 1% at 1st Quarter 2008 across all programs and remained the same for quarter two. Most of the data entry errors for charting were related to time of day and were internally corrected. These time-of-day entries do not affect the validity of the billing.

None, for information only.