State of Colorado Department of Health Care Policy and Financing Claims and Encounter/411 AUDIT

April 2018

Tips for successfully completing the 411 Audit

Purpose and Process of the 411 Audit

- For the state to check the accuracy of claims submitted to HCPF for Medicaid services
- State randomly selects 411 claims/encounters for each BHO in categories they are focusing on.
  - For the last few years, those categories have been Prevention/Intervention, Clubhouse/Drop-In Centers, and Residential Treatment
- Beacon requests documentation for each claim from the provider and audits according to the state instructions and the USCS coding manual.
- State over-audits 30 encounters to double check our results

Audit Structure

- The 411 audit asks for responses in 19 areas.
  - Items 1 to 11 have a yes (1) or no (0) response.
  - Items 12 to 17 allow the auditor to enter data. The auditor is asked to enter the what the data SHOULD BE if it is inaccurate or doesn't match between the documentation and the encounter.
  - Item 18 asks for what USCS Coding Manual version was used.
  - Item 19 is comments. The auditor should explain any score of 0 or make other comments relevant to the documentation.

Audited Elements

- 1. Procedure code. Auditor is looking for evidence in the note that the procedure code on the claim matches the note, AND that the content of the note meets the documentation requirements in the USCS manual. The service must be eligible for Medicaid payment.
- 2. Diagnosis Code. Auditor is checking to be sure the diagnosis on the encounter documentation matches that in the claim. Diagnosis must be eligible
- 3. Place of Service. Auditor is checking that the place of service described in the documentation matches that reported in the encounter. Place of service must be eligible for the type of service provided (e.g., phone is OK for screening or case management)

Audited Elements…continued

- 4. Encounter Service Category or Program Category. Auditor is checking that the 2-letter Program category for the service is correct in the claim and it is an eligible category for the service provided.
- 5. Encounter Units. Auditor is checking the calculation of units for the type of service provided, applying the +/- 7 minutes variation allowed.
- 6. Service Start Date: Auditor is checking that the start date of the service is the same in the documentation as in the claim.
- 7. Service End Date. Auditor is checking that the end date of the service is the same in the documentation as in the claim.

Audit Elements…continued

- 8. Documented Population. Auditor is checking that the member receiving the service is among the eligible population for that service.
- 9. Duration. Auditor is checking that the duration of the service falls within the allowed range for that service (per unit or per diem). The auditor should calculate the duration in minutes and write it down.
- 10. Mode of delivery. Auditor checks that the mode of delivery (phone, face-to-face, televideo, etc.) is eligible for the service provided.
- 11. Staff Requirements. Auditor is checking that the staff providing the service has credentials that are on the eligible provider list for that service.

Audit Elements…continued

- 12. Procedure code. Auditor records the procedure code of the encounter if it is accurate OR records what s/he thinks the code should be if it is not accurate. Auditor records NA when there is not enough information to make a decision about the code.
- 13. Diagnosis code. Auditor records the diagnosis if it is accurate in the claim OR records what the documentation says is the correct diagnosis if it doesn't match the claim.
- 14. Place of Service. Auditor records the place of service in the claim if it is accurate OR records what the documentation says is POS if it doesn't match the claim.

Audit Elements…continued

- 15. Units. Auditor records the number of units if they were accurate in the claim OR records the number of units that should have been on the claim if they are inaccurate.
- 16. Start Date of Service. Auditor records the date as given on the claim if it matches the documentation OR records the date in the documentation when it doesn't match.
- 17. End Date of Service. Auditor records the date as given on the claim if it matches the documentation OR records the date in the documentation when it doesn't match.

Audit Elements…continued

- 18. USCS Version Used. Encounters/claims selected for audit may fall in the effective dates of different USCS versions, so the auditor states which version was applied in auditing this encounter.
- 19. Comments. Auditor writes down duration in minutes and explains any item that did not meet standard.

Areas for attention

- Procedure Code
  - Procedure code must be correct for nature of service and duration, but is ALSO must have documentation that meets minimum standards as listed in the Coding Manual. Particular concerns are template notes that are the same for every person and notes that do not contain sufficient detail.
    - H0023 and H0002 represent most errors.
      - » H0002 is a brief screening whereas, H0023 is outreach.
      - » H0023 should only be used when **CLINICAL** follow-up information is provided. Scheduling appointments cannot be billed.

Areas for attention

- Diagnosis
  - Difficulties arise when the diagnosis is not printed on the progress note itself. If the diagnosis is in the psychiatrist evaluation or on the patient face sheet, it may not match what was submitted in the claim. We also have to count it as an error when the complete number of digits in the diagnosis is not in the claim (e.g., F31.3 vs. F31.30 or F31.31).
    - Most errors were found with discrepancy between diagnosis on the record and diagnosis in the encounter.
      - » It is recommended the diagnosis is printed on every progress note to avoid discrepancies.
      - » If additional diagnoses are made during the course of treatment, please be sure to include this in the notes.

Areas for attention…continued

- Place of Service
  - There is confusion between OFFICE as POS (code 11) or CMHC (code 53). Office should be used by private providers and CMHC by mental health centers. OTHER POS (code 99) is appropriate for service locations in the community. Telephone is usually thought of as a mode of delivery rather than a place of service, but use of Code 99 for Telephone is acceptable
    - Most errors occurred with use of Office (11) and CMHC (53).
      - » MHC should be coded as 53
      - » Independent providers should use code 11.
      - » Please be sure the code is used throughout the documentation to maintain consistency.

Areas for attention…continued

- Mode of Delivery
  - Please refer to the Uniform Service Coding Manual for allowable Mode of Delivery.
    - The most common error was delivery documented as "written" when the service was face-to-face.
- Duration
  - It is easy to miscalculate duration when lengthy services are provided (e.g., clubhouse or drop in). Be alert to when duration changes from units to per diem.

Areas for attention…continued

- Units
  - Most errors were from a miscalculation of units for the service.
    - Be sure to refer to the Uniform Service Coding Standards Manual as to if a unit is encounter based or time based.

- Minimum Staff Requirements
  - Most errors were from missing information concerning staff credentials meeting USCS standards.
    - Be sure to refer to the Uniform Service Coding Standards Manual to determine required credentials for each service.
    - Be sure the providers credentials are documented in the chart.

Questions

- Please contact Jeremy White or Rhonda Borders in the Beacon Health Colorado Quality Department for questions.
  - Jeremy White: 719-226-7794 or Jeremy.white@beaconhealthoptions.com
  - Rhonda Borders: 719-580-2010 or Rhonda.borders@beaconhealthoptions.com

Thank you