Program Integrity

Auditing Medical Records by the Office of Program Integrity

MISSISSIPPI DIVISION OF MEDICAID

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Topics to be Discussed

- Overview of Program Integrity
- Purpose of a Medical Record
- Contents of a Medical Record
- Documentation Techniques
- Results/Findings from Audits
- Outcomes from Investigations

Office of Program Integrity (PI)

- To identify and stop fraud and abuse in the Medicaid Program and MSCAN Program;
- To identify weak areas in policy and the Medicaid Enterprise System (MES);
- To make recommendations for change and improvement; and
- To investigate cases of possible provider and beneficiary fraud or abuse

Mississippi Policy

Title 23 of the Mississippi Administrative Code

Part 200 Chapter 1 Rule 1.3 -- Maintenance of the Records

Part 200 Chapter 1 Rule 5.1 -- Medically Necessary

Part 305 -- Program Integrity

Purpose of a Medical Record

- ✓ Provides quality of care
- ✓ Required in order to receive accurate and timely payment for services
- ✓ Chronologically report the care a patient received
- ✓ Used to record pertinent facts, findings, and observations
- ✓ Assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring over time

Medical Necessity of Medical Record

Medical necessity is considered to be the defining point that makes medical services justified as reasonable, necessary, and appropriate based on evidenced based standards of care.

Contents of a Typical Medical Record

Each medical record must be complete, legible, and contain:

- Patient's complaint
- Reason for visit
- Signs and symptoms
- Past family and social history
- Examination
- Diagnosis
- Plan of care
- Chronic problems and illnesses
- X-ray, lab, pathology, surgery procedure documentation
- Emergency room visits
- Immunizations
- Medications and prescriptions
- Telephone communications
- Insurance information

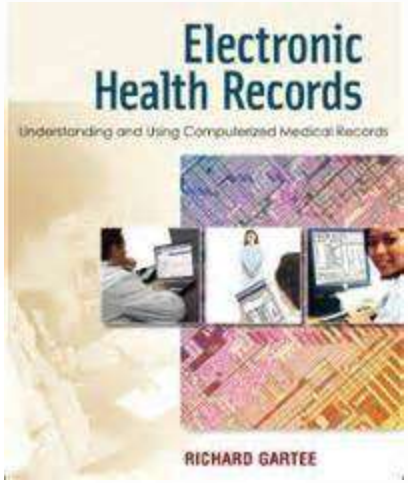
Forms and Consents – Usually found in the medical record

- Consent for general treatment
- Consent to file insurance
- Assignment of benefits
- Medical record release
- Informed consent
- HIPAA
- Financial policy

IF IT IS NOT DOCUMENTED, IT HASN'T BEEN DONE!!

Medical Records Documentation Techniques

- ✓ Dictation
- ✓ Handwritten
- ✓ Templates
- ✓ Electronic



Medical Record Entries

- Medical records should be generated between 24-48 hours after service
- Late Entries
- Addendums
- Medical Record Corrections

Late Entry

- Supplies additional information that was omitted from the original entry
- Identify the new entry as a “Late Entry” in the medical record
- It should contain the current date
- Only used when necessary

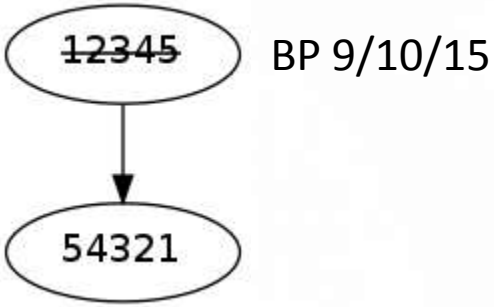
Addendum

- Provides information that was not available at the time of the original entry
- It should contain the current date
- Reason for the addition or clarification of information being added
- Only used when necessary

Medical Record Corrections

- Line through the incorrect information
- Initial and date the corrections

Procedure Code ~~99212~~ BP 9/10/15



Things Not to Do

- No white out
- No black out
- No erasing
- No cover-up of area in any form

Falsifying Documentation

This is a felony offense and includes:

- Creation of new records when records are requested
- Backdating entries
- Postdating entries
- Predating entries
- Writing over or adding to existing documentation

Medical Record Signatures

- All medical record entries should be signed and dated usually within 48-72 hours of the encounter, but certainly before the claim is filed
- Stamped signatures are not allowed
- The author of the note should be clearly identified
- Signature should be **legible**

Electronic Signatures

- Imprinted by password
- Responsible for anything that bears signature
- Do not share password
- Must take the same steps to protect their EMR password

Other Medical Record Entries

- MAR – Medication Administration Record
- Immunization forms
- History sheets
- Link to main medical record

Organization and Retention of the Medical Record

- No specific guidelines on how to arrange chart
- Must be kept for 5 years

Auditing the Medical Record

The audit must examine the patient encounter based solely on the information provided to the auditor.

3 notations of each audit:

- Services billed
- Documentation of level of services billed
- Medical necessity level of the services billed

Auditing the Medical Record Con't.

Check to make sure medical record entry contain:

- Right Beneficiary
- Right Date of Service
- Correct Procedure Code
- The site of service
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided
- That services furnished have been accurately reported

Additional Resources

- E & M Checklist
- E & M Service Guide
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf

IF IT IS NOT DOCUMENTED, IT HASN'T BEEN DONE!!

Typical Results from Audits Conducted by PI of Mental Health Providers

- Improper recruitment/referral process for beneficiaries
- Inadequate medical records documentation
- Beneficiaries exceeding allotted yearly units
- Billing services that are not medically necessary
- Policy vague and lacked edits

Outcomes from Investigations Conducted by PI

- Request policy changes
- Place edits in system
- Streamlined approval process for newly enrolled mental health providers
- Referrals to MFCU
- Payment suspensions
- Possible indictments

QUESTIONS ?

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Test Your Knowledge

What documents are contained in the Medical Record?

A. History and Physical Exam
B. Plan of care
C. Insurance Information
D. Reason for Visit
E. All of the above

Documentation techniques include dictation, handwritten, electronic and sticky notes.

- True
- False

How long must records be kept?

- 3 years
- 10 years
- 5 years
- 7 years

Backdating is considered falsifying documentation.

- True
- False

If it wasn't documented, it wasn't done is an example of which of the following?

1. Physician order for lab results are documented in the medical record
2. No order for penicillin injection that was documented as given in the office
3. Crown placement but exam indicates tooth pulled on previous visit
4. No physician signature on medical record