Provider Network Update

Provider Documentation Training

Provider Documentation Requirements and Recommendations

Presented by: Program Integrity, Special Investigations Unit, and Compliance

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Disclaimer:

The information in this presentation is not intended to constitute legal advice.

This presentation includes recommendations and suggestions relating to medical record documentation, but is not meant to be considered all-inclusive for all levels of care.

Providers are responsible for complying with all federal and state laws, regulations, and guidance pertaining to the Medicaid program and should always validate that the materials being referenced include the most up-to-date content.

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Agenda

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- **Provider Documentation Overview**
- **Medical Records**
  - Requirements
  - Common Issues
- **Treatment Plans & Progress Notes**
  - Requirements
  - Common Issues
- **Encounter Forms**
  - Requirements
  - Common Issues
- **Resources**

Provider Documentation Overview

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Pennsylvania HealthChoices is dually regulated by both the Centers for Medicare & Medicaid Services (CMS) and the Pennsylvania Department of Human Services (DHS).

Because both federal and state dollars are used to pay the claims for Members, there are requirements that Providers submit specific documentation to confirm that the services being billed for are being received by eligible beneficiaries.

Medical Record documentation standards can be found in the following places:

- The Federal Register
- The Pennsylvania Code
- Pennsylvania Medicaid Bulletins
- PerformCare Provider Manual

Provider Documentation Overview

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The standards set by the federal and state government are the minimum standards. Each managed care organization can then add additional documentation requirements.

In accordance with their contract, PerformCare Providers are required to maintain documentation for the provision of services to our Members. This training will highlight some of the specific documentation requirements, however, Providers should review the PerformCare Provider Manual and other resources to ensure compliance will all requirements for each level of care.

The goal of this training presentation is to assist our Providers in becoming familiar with these record keeping requirements and advise them of where to find additional information and resources on this topic.

Medical Records

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Medical Record Documentation Requirements

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Pennsylvania law sets the minimum standards for documentation requirements for all patient medical records.

Provider records must meet the criteria outlined below:

- **PA Code Title 55, § 1101.51(e)(1) General standards for medical records.**
  - (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. Alteration of the record shall be signed and dated.
  - (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.

Medical Record Documentation Requirements

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- **PA Code Title 55, § 1101.51(e)(1) continued…**
  - (vi) ***The record shall indicate the progress at each visit, change in diagnosis, change in treatment*** and ***response to treatment***. [Progress Note]
  - (vii) The record shall contain ***summaries of hospitalizations and reports*** of operative procedures and excised tissues.
  - (viii) The record shall contain the ***results, including interpretations of diagnostic tests and reports of consultations.*** *Note: This regulatory requirement may not be applicable in the behavioral health setting*.
  - (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.

Medical Record Documentation Requirements

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Additional Requirements from the PA PerformCare Provider Manual

- Document Member's name and MA ID and/or SSN on each page of a paper record and each entry of an electronic record.
- Document relevant medical conditions.
- Document known allergies and known adverse reactions including those to medication.
- Document medication names and prescribers.
- Document past/present mental health treatments and symptoms including past/present suicidal ideation, homicidal ideation, or self-injurious behavior.
- Document screening for substance abuse.
- Document screening for tobacco use and note if cessation information was provided.
- Document efforts to identify cultural preferences for the Member/family.
- Document completion of a trauma assessment and referral if appropriate.

Direct Link to Source:

PA PerformCare Provider Manual - Chapter VII, Medical Record Standards

Medical Record – Common Issues and Problems

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- ***Top Finding*** - The documentation does not support the claim submitted.
  - Providers must ensure that all time billed to Medicaid is properly accounted for.
  - Documentation should detail what specifically was done during a Member's treatment/encounter.
- Required patient information is missing such as full name, MA ID, or SSN.
- Required signatures are missing.
- Files are either illegible or unable to be verified for services billed.
- Improper billing including: billing for services not rendered, incorrect code or modifier, rounding or combining units, billing for overlapping timeframes, billing for non-billable services.
- The billed services were not performed by the billing provider.
- More than 10 patients participating in a group session.
- Missing documentation, such as complete Treatment Plans, Progress Notes, and clock time (depending on LOC).

Treatment Plans

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Treatment Plan Requirements

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Pennsylvania law sets the standard for the minimum documentation requirements for all patient medical records. Specifically, outpatient Provider records must meet the criteria outlined below:

- **PA Code Title 55, § 1153.42 Ongoing responsibilities of providers.**
  - In addition to the requirements listed in § 1101.51(e), **outpatient psychiatric clinics** and **outpatient psychiatric partial hospitalization facilities** shall also adhere to the additional requirements established in this section.
  - Medical records of MA patients receiving outpatient psychiatric clinic and outpatient psychiatric partial hospitalization services shall include the following:
    - The **treatment plan** shall include:
      - The treatment plan goals.
      - Services to be provided to the patient in the clinic or partial hospitalization facility or through referral.
      - Persons to directly provide each service.
    - As part of the **progress notes**, the frequency and duration of each service provided shall be included.

Treatment Plan Requirements

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Pennsylvania state requirements specific to Treatment Plans:

- **PA Code Title 55, § 5100.15(a)(5) Contents of treatment plan.**
  - A comprehensive **individualized plan of treatment** shall 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 the Office of Mental Health and Substance Abuse Services, as part of the licensing approval process.

Treatment Plan Requirements

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There are specific criteria specific to drug and alcohol treatment records that are outlined below:

- **PA Code Title 28, Chapter 710. Drug and Alcohol Services, § 710.23. Patient Records**
  - In addition to the requirements contained in § 115.32 (relating to contents), **the patient's medical record shall contain a drug and alcohol support plan, follow-up information, and an aftercare plan**, if applicable.

Treatment Plan Requirements

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Additionally, there are specific requirement for other Nonresidential Provider types outlined below:

- **PA Code Title 55, § 5200.41(a) Records:**
  - 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: patient identifying information; referral source; presenting problems; appropriately signed consent forms; medical, social, and developmental history; diagnosis and evaluation; **treatment plan**; **treatment progress notes for each contact**; medication orders; discharge summary; referrals to other agencies, when indicated.

- ***NOTE*: Requirements may vary based on the specific level of care provided. Providers should review PA Code, Title 55, Part IV. Mental Health Manual to ensure they are meeting the standards specific to the appropriate level of care.**

Treatment Plan Requirements

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Treatment Plans Must Contain the Following Elements:

- The patient's treatment goals.
- The services to be provided.
- The provider of the listed services.
- The frequency and duration of each service provided.
- The required signatures of involvement and agreement with the Treatment Plan.

Treatment Plan Requirements

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Additional Requirements from the PA PerformCare Provider Manual

- The Treatment Plan goals must be specific and measureable.
- The target dates for completion must be individualized and specific to each goal/objective.
- The Treatment Plan must include measureable baseline information.
- Inclusion of a Member strength assessment incorporated into the Treatment Plan.
- The Treatment Plan must contain measureable discharge criteria and clear aftercare plan.
- Treatment Plans for Members experiencing ongoing symptoms without improvement or regression of progress should include notes indicating appropriate changes made to the Treatment Plan.

Direct Link to Sources:

PA PerformCare Provider Manual - Chapter VII, Medical Record Standards

PA PerformCare Manual – Chapter XI, Expectations for Treatment Planning and Progress Reporting

Treatment Plan – Common Issues and Problems

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- The Treatment Plan is missing the Clinician's signature, credentials, date, or the signature is illegible.
  - Clinician's may maintain a signature log to use for purposes of record review to validate signatures.
- The Treatment Plan was not signed and dated by the Member/Representative.
- The Treatment Plan is missing one of the required elements and/or is incomplete for the date of service.
- There is a correction made to the Treatment Plan entry and it was not initialed and dated.
- There is no valid Treatment Plan for the date of service.
- Supporting documentation was not attached when required.

Progress Notes

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Progress Notes Requirements

Pennsylvania law sets the minimum standards for documentation requirements relating to Progress Notes.

Progress Notes must meet the criteria outlined below:

- **PA Code Title 55, § 1101.51(e)(1) General standards for medical records.**
  - (vi) ***The record shall indicate the progress at each visit, change in diagnosis, change in treatment*** and ***response to treatment***. [Progress Note]

Progress Notes Requirements

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Additionally, the Pennsylvania Office of Medical Assistance has issued guidance in the form of a bulletin for Providers relating to Progress Note Requirements.

- **PA MA Bulletin 29-02-03*** Documentation and Medical Record Keeping Requirements (March 21, 2002)**
  - This bulletin is applicable to all **psychologists, outpatient psychiatric clinics and psychiatric partial hospitalization programs** enrolled in the MA Program. Failure to comply with documentation and medical record keeping requirements may result in the Department's termination of a provider's enrollment in the MA Program, provider restitution or Departmental recoupment of overpayments.

  - The documentation of treatment or **progress notes**, at a minimum, must include:
    - The specific services rendered;
    - The date that the service was provided;
    - The name(s) of the individuals(s) who rendered the services;
    - The place where the services were rendered;
    - The relationship of the services to the treatment plan, specifically any goals, objectives and interventions;
    - Progress at each visit, any change in diagnosis, changes in treatment and response to treatment; and
    - The actual time in clock hours that services were rendered.

***Per MA Bulletin 29-02-03 referenced above, "Providers should review their record keeping practices to ensure compliance with applicable Federal and State statutes and regulations, as well as, compliance with their licensing and approval standards."

Progress Notes Requirements

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- The Progress Notes should address the following questions in detail:
  - ***Where*** is the service being provided to the Member?
  - ***Why*** is the Member there? What is the goal/s of the session?
  - ***What*** specific intervention/service is being provided to the Member by the clinician and how the intervention/service was implemented in session for the Member?
  - ***What*** is the Member's response to the intervention/service?
  - ***What*** is the plan for follow-up for this Member?
  - ***Who*** is present during the intervention/service?
- A Progress Note must be completed for each billable encounter.
- The Progress Notes should include the date of service and start/stop times. *Note*: Services that are billed at a per diem rate may not require start/stop times to be documented.
- The Progress Notes should include a narrative with the clinical justification to support utilization and time billed.
- The Progress Notes should include supporting documentation when necessary.

Progress Notes – Common Issues and Problems

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- The Progress Note is missing from the record.
- The Progress Note is illegible/unable to be verified.
- The Progress Notes is missing the required narrative of what occurred in session.
- The Progress Note is insufficient due to missing information such as the reason for the encounter, symptoms or behaviors, diagnosis, treatment plan goals and objectives, intervention, and next steps in treatment.
- The Progress Notes are almost identical or contain very few changes from note to note (cookie-cutter).
- The Progress Note submitted for payment contains non-billable or improperly unbundled services.
- The Progress Note contains inaccurate or overlapping units billed.
- The Progress Note contains information that is in conflict with the Encounter Form (service code, units, time).
- The Progress Note does not provide the specific location where services were rendered.
- The Progress Note is missing start/stop times with AM and PM noted.
- The Progress Note is not signed and/or dated by the clinician or is unable to be verified in the record or with the use of a signature log.
- The Progress Note contains edits/corrections that are not initialed and/or dated.
- The Progress Note is not signed and/or dated by the Member. [*Please Note*: This is not required for all levels of care.]

Encounter Forms

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Encounter Form Requirements

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The Pennsylvania Office of Medical Assistance has issued guidance in the form of a bulletin for Providers relating to Encounter Form Requirements.

- **PA MA Bulletin 99-89-05 Signature Requirements and Encounter Forms (May 26, 1989)**
  - This bulletin is applicable to all providers enrolled in the Medical Assistance Program. It lists the information that must be contained in an **Encounter Form** and the signature requirements for Encounter Forms. All Encounter Forms must be signed or note "signature exception" as outlined in the bulletin.

- **PA MA Bulletin 99-03-21 HIPAA Transaction Code Sets Update (October 16, 2003)**
  - This bulletin outlines procedures for Providers to keep a Member's signature on file and the requirement that **Encounter Forms** are signed by the Member and kept on file by the Provider for at least four years.

Encounter Forms must contain, at a minimum, the following elements:

- Member Certification Statement with signature of Member designee as applicable.
- Provider Name and MAID number.
- Member Name and MAID number.
- Type of service.
- Date of service. [*Please Note*: Start/Stop time not required but recommended.]

Encounter Form Requirements

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- Completed Encounter Forms are required for all behavioral health services ***except*** inpatient hospital, emergency room, and telephone crisis services.
- Separate Encounter Forms must be used for each Member.
- Providers may develop their own Encounter Forms or use the template created by the Pennsylvania Department of Human Services (MA 91). [http://www.dhs.pa.gov/cs/groups/webcontent/documents/form/s_002560.pdf]
- Providers must retain signed encounter forms for no less than 4 years. Due to the varying lookback period for state and federal regulatory bodies, Providers may wish to retain documentation for a longer period of time.

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

ENCOUNTER FORM

PROVIDER NAME	PROVIDER NUMBER
ADDRESS	

"My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws."

DATE	RECIPIENT NUMBER	RECIPIENT'S SIGNATURE I have read and agree with the above statement.

Encounter Form - Common Issues and Problems

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- The Encounter Form is missing for Medicaid paid services.
- The Encounter Form is not signed by the Member (or parent, guardian, or agent).
- The Encounter Form does not include the type of service.
- The Encounter Form information conflicts with the Progress Note (dates of service do not match, billed unit discrepancies).
- The Electronic Record System does not capture all of the required elements of the Encounter Form and is therefore found to be invalid.
- The Encounter Form is missing other required information.

Resources

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- **PA Code, Title 55, Part III. Medical Assistance Manual [**http://www.pacode.com/secure/data/055/partIIItoc.html]
  - Chapter 1101. General Provisions
  - Chapter 1151. Inpatient Psychiatric Services
  - Chapter 1153. Outpatient Psychiatric Services
  - Chapter 1223. Outpatient Drug and Alcohol Clinic Services
- **PA Code, Title 55, Part IV. Mental Health Manual [**https://www.pacode.com/secure/data/055/partVIItoc.html]
  - Subpart C. Administration and Fiscal Managing
    - Chapter 5100. Mental Health Procedures
  - Subpart D. Nonresidential Agencies/Facilities/Services
    - Chapter 5200. Psychiatric Outpatient Clinics
    - Chapter 5210. Partial Hospitalization
    - Chapter 5221. Mental Health Intensive Case Management
    - Chapter 5230. Psychiatric Rehabilitation Services
  - Subpart E. Residential Agencies/Facilities/Services
    - Chapter 5300. Private Psychiatric Hospitals
    - Chapter 5310. Community Residential Rehabilitation Services for the Mentally Ill

- **MA Bulletins: 29-02-03; 99-03-21; 99-89-05; 99-97-06. [**http://www.dhs.pa.gov/publications/bulletinsearch/index.htm]

- **PA PerformCare Provider Manual [**https://pa.performcare.org/assets/pdf/providers/resources-information/provider-manual.pdf]

Questions?

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