HERITAGE BEHAVIORAL HEALTH CENTER
NEGLEY AWARD APPLICATION 2003

I. Introduction

A pattern or practice of poor documentation places healthcare providers at enormous risk for charges of healthcare fraud. Among other things, this can result in substantial paybacks, fines and monetary penalties that can severely damage a provider's ability to optimize its resources for the provision of services.

While healthcare compliance has been on the radar screen of medical healthcare providers for at least a decade, it has only recently become a compelling issue for most behavioral healthcare providers. Among the many compliance issues that can place a healthcare provider at risk is submitting a bill for clinical services prior to verifying that a progress note exists to support the bill.

To address this issue, Heritage Behavioral Health Center has developed a process that makes it highly unlikely it would submit a bill for services without credible verification that a progress note exists to support the bill and that the progress note would be accurate and complete. This process also improved the quality of the clinical record.

II. Background

In the 1 990s, Heritage engaged in billing practices that were common at the time but that were becoming increasingly problematic because of heightened government interest in healthcare compliance. Because of this, in early 2000 we began to pay far closer attention to compliance issues. That summer, key staff representing a wide range of the organization began meeting with a nationally recognized consultant on a monthly basis in order to improve our understanding of healthcare compliance and to conduct a risk assessment of key compliance concerns.

By the fall of 2000, we determined that our number one priority was to verify the existence of supporting documentation prior to billing. Other related priority items we identified were accurate coding, thorough

documentation, timely completion of documentation, and accurate transfer of information from the clinical record to the billing program. (FY 0 1-02 Compliance and Integrity Plan, Attachment A)

III. Our Best Practice Documentation Process

Given the way our billing and clinical documentation system operated prior to implementing our best practice process in February 2001, our Accounts Receivable (AR) staff had no way of knowing whether a particular bill had a progress note to match it, much less whether the codes used were accurate or the components of the note complete. We would only know this after a retrospective audit. Even then, we only knew the status of a sample of documentation. This system made it impossible to ensure that a progress note existed prior to submitting a bill.

To correct this, Heritage designed and implemented a process in February 2001 in which the AR staff submitted a bill only after they had received credible verification that a progress note existed to support it. Since we tied this process to our Electronic Clinical Record (ECR), as well as to our internal clinical documentation training (Attachment B), this process also ensured that the codes used would be accurate and the components of the progress note complete.

Our process allows the clinician to enter his/her schedule, billing information and progress notes directly into the ECR (Attachment C). Initially, the clinician enters client contact information in the scheduler module of the ECR (either before or after the actual contact). The ECR completes an edit check to ensure the clinician is qualified to provide

the service coded, that the code used is appropriate for a given program, and that the code can be applied to a client based on that client's registration information.

The clinician then enters his/her clinical contact information into the progress note module of the ECR. We

designed the progress note screen so that the clinician must document to each of five areas required for a complete individual contact note and for the four areas required for a group session note (Attachment D). Upon completing a progress note, the clinician prints it. When the clinician does this, the ECR secures the note so that no further changes can be made.

The clinician is expected to print his/her progress notes for a given day within twenty-four hours, to bundle them, and to print a Staff Activity Log (Attachment E). This log identifies those clients whom the clinician served, for how long, the location where the clinician provided the service, and the billing code selected by the clinician.

The clinician reviews the Staff Activity Log, ensures that there is a progress note for each service listed on it, checks that the information on the log matches that contained in the progress notes, and signs the log verifying it is accurate. By signing the log, the clinician is authorizing the AR staff to bill for those services. The clinician sends the bundled progress notes and the signed log to his/her supervisor. The supervisor double-checks that there is a progress note for every activity listed in the log, completes a random quality review (e.g., that the documentation matches the code used, sufficiency of content, etc.) and signs the log verifying a progress note exists for each service listed on it. The supervisor then sends the Staff Activity Log with the progress notes to the AR staff for billing. They bill from the Staff Activity Log and send the bundled progress notes to Medical Records for filing. (The printing of hardcopy progress notes has been a temporary
measure related to the issue of authentication of electronic signatures. Heritage expects to resolve this issue by the end of the year.)

The AR staff has two signatures verifying that a progress note exists to support each bill. Because of this, it is very rare that we would submit a bill without an existing progress note to support it. Furthermore, this process, in combination with our documentation training, makes it unlikely that the codes used will be inappropriate or that

the required components for a complete progress note will go unaddressed.

To maximize timely completion of progress notes, the AR supervisor produces an Untagged Services Report (Attachment F) that she brings to our Leadership Council (management team) on a weekly basis. This report identifies progress notes started but that remain incomplete. Additionally, the MIS supervisor produces a Daily Staff Service Hour Report (Productivity Hours) (Attachment G) that he brings to Leadership Council on a weekly basis as well. This report identifies the number of hours each clinician has documented on a daily basis and that he/she has authorized AR to bill. It also identifies clinicians who have completed no progress notes.

Clinical supervisors on our Leadership Council communicate the information from these two reports to the direct supervisors of staff identified as having incomplete/no progress notes or other productivity issues. The direct supervisors then work with their staff to complete their progress notes in a more timely fashion. Prior to the use of the ECR, it took an average of nine days to file a progress note in the chart from the time the clinician provided the service. It now takes an average of two days. Further, Heritage witnessed a substantial reduction of risk as evidenced by a precipitous decline in paybacks to state funders because of deficiencies uncovered in yearly audits. For example, in 1999 and 2000, Heritage repaid a combined total of just over $5000 in each of these two years to the Office of Alcohol and Substance Abuse (OASA) and the Office of Mental Health (OMH). However, because we implemented our best practice process in February of 2001, Heritage repaid OASA and OMH a combined total of only $774 for 2001. For 2002, we repaid OASA just $60. Heritage's OMH audit results were so favorable in 2001, they exempted us from an audit in 2002.

IV. Quality of Care

Heritage designed the best practice process described above in order to reduce the legal and financial risks associated with submitting bills prior to establishing that a progress notes exist to

support the bills, inaccurate use of codes, and progress notes lacking in quality and content. This best practice process also improved the accessibility and quality of the clinical record because clinical information is placed into the chart quicker and the note itself is more complete.

What these improvements mean is that clinicians who require current client information are in a better position to provide care to those clients. Examples of clinicians in this situation would be those who work with clients in crisis; those who work with clients who have multiple internal providers; and/or those covering for other clinicians due to sickness, vacation, etc. In all these situations, client care is positively affected by clinical information that is as up-to-date and complete as possible.

V. Summary

In short, the best practice documentation process we are nominating has allowed Heritage to do three things. It has virtually eliminated the likelihood that Heritage would submit a bill for a clinical service without a progress note to support it. It has substantially enhanced the quality of the progress note. And it has significantly increased the value of the client record for clinical decision-making.

Please provide a brief paragraph describing the history and scope of your organization (limit 200 words).

Heritage Behavioral Health Center, Inc., is a charitable (501-c-3) service corporation governed by a 15 member Board of Directors. Founded in 1956. its corporate mission is to provide high quality, comprehensive mental health and substance abuse services. including prevention, crisis resolution, short—term treatment and support services, without regard for the client's ability to pay. Heritage operates out of five sites in Decatur, Illinois, with our primary site located **at** 151 North Main Street in the center of the city. It is the largest provider of community—based behavioral health care in greater Macon County, with an annual operating budget of approximately $8.9 million, supporting approximately 191 staff and a broad continuum of outpatient and

residential services. Treatment services for mental illness and/or addictive disorders are provided to nearly 3,500 clients each year, with thousands more receiving prevention and crisis intervention services. Heritage is accredited by the Joint Commission on the Accreditation of Healthcare Organizations and recognized by the Illinois Department of Human Services as a licensed provider of substance abuse services and a certified provider of Medicaid mental health services.