

QUALITY MANAGEMENT MEETING NOTES

1/11/11

Attendance

Candice Yeargin, Mental Health Board/FC	Kemberly Daily-Johnson, Pioneer Center
Chris Gleason, Family Service	Melissa McGraw, Turning Point
Scott Campbell, Family Service	Tammy Stroud, Mental Health Board
Cathy Garrey, Mental Health Board	Scott Brown, Family Service
Sonya Jimenez, Mental Health Board	Cheryl Wyatt, The Advantage Group
Wendy Neuman, Mental Health Board	Julie Gibson, Thresholds
Susan Charles, Mental Health Board/FC	Jen Cox, Family Alliance
Liz Doyle, Mental Health Board/FC	Lori Nelson, Family Service
Kim Larson, Adult & Child Therapy Services	Ronica Patel, Youth Service Bureau
Barb Szul, Transitional Living Services	Debbie, Currey, Health Department
Astrid Larsen, Crisis Services	Vickie Johansen, Mental Health Board

Signatures

Cathy Garrey distributed an article about provider signature guidelines (*see attached*).

Documentation Committee: Review of audit tool

Scott Brown distributed a draft of the Post Payment Review Tool and noted that it can also be used as an internal tool. Both the post payment report and SAMHSA information were used to create the auditing tool. The form was reviewed and the following suggestions were made: add a signature line for the supervisor, add a follow-up and findings/plan of correction section and at the end add a statement regarding client participation and medical necessity. Chris Gleason also noted that Substance Abuse is not included and will work with Scott to add that. The tool will provide feedback to the provider and can be used to show that auditing is being completed. Agencies can add to the tool according to their needs. Liz Doyle will be piloting the tool for a June SAMHSA review.

It was suggested that this would be a good tool to add to the training manual and it was asked if the Mental Health Board would support creating the training binders/manuals. Cathy Garrey said the Mental Health Board could supply one manual for each agency, but it would be the committee's responsibility to keep the manual current and updated.

Group Discussion:

- ❖ Cathy Garrey distributed copies of an article, from a Rockford paper, about Rosecrans and the veteran beds they have available. She also noted that Janet Wattles received a veteran's grant and gave the committee an update on the Lake-McHenry veteran's transformation grant. There are 21 members of the Governing Council, 19 of which are vets. Their first meeting was last week and the advisory meeting will take place tonight at the Shah Center in McHenry. A Crystal Lake home has been donated, rent free for 1 year, to be used as a possible drop-in center. Pioneer Center will be posting 2 Recovery Specialist positions, Family Service will be adding a therapist and TLS a case manager, as well as providing oversight.
- ❖ Wendy Neuman and Kemberly Daily-Johnson were congratulated for recently achieving healthcare compliance (HCCA) certification. Lori Nelson was also congratulated on her promotion to Executive Director of Family Service. And Tammy Stroud was introduced as the new TBI Coordinator at the Mental Health Board.

Other

- ❖ Astrid Larsen was asked if Crisis has received calls due to the recent events in Arizona and should an article be put in the paper addressing it? She said they have not received any related calls, but an educational article about a clinician's duty to warn versus confidentiality would be a good idea. Debbie Currey met with the Northwest Herald's editor and he said they would be willing to run articles about

mental health issues. Cathy will follow up with Barbara Iehl to see about resubmitting an article she did with Dr. McMasters.

- ❖ Astrid also reported that the recidivism rate is high. Individuals are not receiving services either by choice or because services are no longer offered, long waiting lists, lack of funding or lack of psychiatrists available and are using Crisis as a service provider. Astrid will send out a list of those with the high recidivism rates but she noted that many of these clients are not affiliated with an agency. Clinical reviews may be helpful in those situations. There was discussion about the need for better discharge planning as the linkage services were cut by the State on July 1st. Astrid said to possibly have Crisis involved with discharge planning and that she will bring it up at the next Crisis P.I. meeting. It was suggested to let the State know what effects the cuts have made through the Continuity of Care and/or State calls.
- ❖ Chris Gleason reported that Family Service is building up services to meet client needs, including reinstating the Recovery Specialist program. He provided his cell phone number and said to contact him when/if issues arise, have questions, need clarification on service access, etc.
- ❖ Julie Gibson reported that Thresholds has 3 openings in their residential program and that they recently received 91% on their post payment review.

Next Meeting: March 8, 2011, 9:00 – 10:30 a.m. at the Mental Health Board

2011 Meeting Schedule: March 8 September 13
 May 10 November 8
 July 12

Committee Break-Out Session Reports:

CLINICAL DOCUMENTATION COMMITTEE

***Team meeting 1st Thursday of the month at Family Service*

*Scott Brown

Goals	Person(s) Responsible	Target Date
Revise audit tool	Committee	Mid Feb.
Look at needs for a successful reauthorization process	Committee	Mid Feb

EDUCATION COMMITTEE

*Scott Campbell, Wendy Neuman, Ronica Patel, Vickie Johansen

Goals	Person(s) Responsible	Target Date
Committee will be meeting to review recently completed survey and plan trainings. Reviewed top requested topics – PTSD, Anxiety, Depression, etc	Committee Wendy Neuman	To be planned
Benefits training workshop for FRDs & Recovery Specialists is planned (20 max)	Wendy Neuman	Already scheduled
EAP Supervisory/Management Training seminar can be offered to Network. Wendy will contact Michelle Durpetti at F.S.	Wendy Neuman Michelle Durpetti	TBD
PTSD workshop highly requested. Will contact Alexian Brothers, Streamwood. 708 currently doing the CBT/Trauma training – Deb Pender	Wendy Neuman Ronica Patel	TBD
Wendy has reserved room space at Family Service from now through November 2011	Wendy Neuman	

CORPORATE COMPLIANCE COMMITTEE

No new report/additional report (1/11/11)

Provider signature guidelines and solutions:

“Autograph, please!”

By Janet Marcus, CPC

Editor's note: Janet Marcus is Director of Revenue Cycle Services at Sinaiko Healthcare Consulting, one of the nation's leading independent health care management consulting firms. She works with health care organizations nationwide on a diverse range of compliance issues. For more information, please go to www.sinaiko.com or e-mail janet.marcus@sinaiko.com.

The Centers for Medicare & Medicaid Services (CMS) requires providers to authenticate the author of record for all Medicare services provided or ordered. The author of the entry is the individual who provided or ordered the service. Authentication may be accomplished through the provision of a hand-written or an electronic signature. CR 5971 (Transmittal #248), effective retroactively from September 2007, was issued to prohibit the use of stamped signatures. These requirements are intended to apply to all providers. As of March 2008, CMS clarified that stamp signatures are unacceptable on any medical record.

Providers of health care services have always been required to append their signature to entries in the patient's medical record documentation. Specifically, the CMS manual states "documentation must be dated and include a legible signature or identity." The Federal Register, 42 CFR 482.24, also makes a similar statement

For certain services, in addition to the signature, the note describing the service ordered or performed requires a notation of time.

This is particularly true for services:

- which depend on chronological order for care over a short period of time (this is most often seen during an acute observation or inpatient facility stay); or
- where time is a factor for the reimbursement; or
- to fully describe the extent to which services were rendered.

Importance of adhering to guidelines

There are more than enough challenges in today's health care environment. The most important reason the signature guidelines exist is to support appropriate and accurate patient care. When providers do not take the time to append their signatures in an acceptable format, it could potentially have a negative impact on the continuity of care for their patients and could also create future "headaches" as a finding during an audit.

In addition to the challenges of patient care, it can be difficult to follow all the documentation and billing rules, submit a clean claim, and collect an accurate payment for services. So, after all that hard work, no one wants their claim to fail an audit due to the lack of a "proper" provider signature, and no one wants to suffer the associated potential consequence of lost revenue.

Guidelines

CMS recently published Transmittal 327, entitled "Signature Guidelines for Medical Review Purposes," effective March 1, 2010, with an implementation date of April 16, 2010. This guidance gives us an inside view of the requirements various government claim audit programs may utilize when they review medical records and claims as part of an audit. This viewpoint focuses on a claim that has been submitted for payment and subsequently selected for audit. The medical record is often requested as part of that review process.

When the auditor/reviewer is determining whether signature guidelines have been met, they may have reason to contact the billing provider and ask a non-standardized follow-up question. The auditor may contact the provider or organization that submitted the claim and ask if they would like to submit an attestation statement or signature log within 20 calendar days. This is another opportunity for the provider to meet the signature guidelines.

In summary, the guidelines, as stated in the CMS Program Integrity Manual, Chapter 3, under section 3.4.1.1 D, "Signature Requirements" and as outlined in Transmittal 327 include:

- Services provided and/or ordered must be authenticated by the author. (There are several signature guideline exceptions outlined in the CMS Transmittal 327 which can be found at: <http://www.cms.gov/transmittals/downloads/R327PI.pdf>)
- Method used may be handwritten or an electronic signature;
- Stamp signatures are not acceptable;
- Handwritten signatures signify that the individual who has signed the record has knowledge, approval, acceptance or obligation for the entry;
- For illegible signatures, auditors can consider evidence in a signature log or

an attestation statement for the purpose of identifying the author of the medical record entry; and

- Situations where the auditor may call upon the provider to inquire if they would like to submit an attestation statement or signature log.

Auditors may consider that the handwritten signature requirement has been met if there is:

- a legible full signature;
- a legible first initial and last name;
- an illegible signature where the letterhead, or other information on the page indicates the identity of the signatory;
- an illegible signature accompanied by a signature log or an attestation statement;
- the initials over a typed or printed name;
- the initials not over a typed or printed name but accompanied by a signature log or attestation statement; and
- an unsigned handwritten note where other entries on the same page in the same handwriting are signed.

CMS considers an electronic signature as meeting the signature requirement; however, they caution providers regarding the potential misuse or abuse of alternate signature methods. If your practice is utilizing an electronic signature on medical records, it is generally recommended, that the electronic signature process, policy, and procedure be reviewed by legal counsel to validate the accuracy and appropriateness of the process. Further, a quality review of the electronic signature process should be conducted along with validation that the electronic signature process in place meets all of the required HIPAA-related guidance.

In our experience, we have observed situations where the accurate application of the electronic signature came into question when a printed copy of the medical record was

presented; however, no indication was noted that the name and credential on the document was created as the result of secure user access. In this instance, the signature was not considered an acceptable final authenticated signature. In other cases, no indication of the author is found on the printed record, even though electronic history would substantiate the user actually made the entry themselves.

Solutions

To ensure your providers append their signature according to the guidelines, we recommend that you start with a review of your current provider signature procedures. Identify if there are providers who are appending illegible hand-written signatures to their medical records. Depending on the results of your assessment, changes may need to be implemented so that the signature guidelines and "best practice" for your group of providers is followed.

Developing a corresponding written policy and procedure that is user friendly will ensure that new providers have a document they can refer to, and providers who may need a refresher

have an accessible, accurate policy reference document. Implementing an internal quality review process will go a long way to ensure that the best practice for provider signature, policy, and procedure are followed.

In situations where there are handwritten signatures, illegibility has been a long-standing issue we have observed during our medical record and claim audits. To combat this issue we recommend:

- implementation of an electronic medical record;
- if this is not an option, creation of a signature log for the "illegible" signors;
- a quality assurance review of the medical notes for the "illegible" providers, prior to claims submission, and you address the issue promptly; and
- review all signature guidelines with providers and give them an outline of what is considered an acceptable signature and what is not.

As Benjamin Franklin once said and, as we say in health care, "an ounce of prevention is worth a pound of cure." <

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