What Psychiatrists Need to Know About... Gold Star Audits

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When a physician hears the word "audit," there is typically a reflexive panic reaction. IRS audits, insurance audits, RAC audits—they all imply some kind of financial payback. There is a new audit to add to the list for psychiatrists who treat Medicaid patients—a Gold Star Audit. Given the number of calls to the NCPA office, let's take a little time to talk about theses audits.

For years, the Local Management Entities (LMEs) have performed yearly monitoring site visits to mental health agencies. Such monitoring was never done for private practices, or what is now called "Licensed Independent Practitioners" or LIPs, unless it was a possible "program integrity" or fraud investigation. So the appearance of an LME/MCO audit team is enough to cause concern to a private practice.

Gold Star audits are different. The original intent of the Gold Star audit was to identify those providers who did NOT need to be audited on a yearly basis. In the new world of Medicaid managed care, limited provider panels, and capitated payments, it was intended to ensure that a provider's office was safe and accessible, that documentation practices were acceptable, and that business practices were sound. If a doctor's office, provider, or agency met a certain threshold in the monitoring process, the LME/MCO would determine that yearly monitoring would not be necessary unless there were a complaint, and the provider could go on with providing good patient care.

What kinds of things are included in Gold Star audits? You can find a checklist on the Department of Health and Human Services (DHHS) website: http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm

Two of the tools specifically—the Office Site Review Tool and the LIP Review Tool—may be useful for any physician's office to use to determine its compliance with state and federal Medicaid law. The Office Site Review Tool is used during the initial on-site review upon the LIP's entry to the LME/MCP provider network. It includes such items as:

- Office accessibility and compliance with fire codes
- Secure record storage
- Documentation of staff HIPAA training
- Adequate patient seating
- Compliance with confidentiality requirements

As currently designed, the LIP Review Tool is used 90 days after the first reimbursement has been made to the physician and is used for all subsequent monitoring of the practice. The LIP Post Payment Tool is used to conduct a post-payment review of the LIP practice. The LIP Service Plan checklist includes the requirements needed

for the individual's treatment plan, including treatment goals. Guidelines that detail each review element are also on the DHHS website.

The Gold Star process and monitoring tools were adapted from those used by Cardinal Innovations (formerly known as PBH). A revision has been in process for a number of months to automate this process and take it statewide. While the original plan was for all the Gold Star processes and tools to be in place by July 1, with all the providers and agencies to have undergone an initial review by October 1, the state is revising those requirements. Instead, DHHS has suspended the requirement that the LME/MCOs must have all providers evaluated in 90 days, and the department is working with the LMEs and providers to clarify the process and improve the procedures. Some LME/MCOs may decide to continue on their plans and continue their reviews. Others are using the time to provide technical assistance to providers.

Some LME/MCOs have already recognized that psychiatrists and LIPs may not be accustomed to the documentation standards required in DMA Clinical Coverage Policy 8C that are used as the basis of the LIP Review Tool. (Let's face it, physician documentation practices may reflect their training, their experience and what is most helpful to them in caring for their patients, not necessarily what it takes to get paid by the insurance company.) Just as insurers have certain documentation standards, so does federal Medicaid and its agents—state DMA and the LME/MCOs. Psychiatrists must use DMA Clinical Coverage Policy 8C as a guideline for the documentation required in a patient note in order for Medicaid to determine that the service was medically necessary and actually performed as billed.

If you provide medical care to patients covered by Medicaid, now—while the audits are not mandatory—may be a good time to contact the LME/MCO network manager to ask for some technical assistance. Call and ask for a knowledgeable staff person to come visit your practice for a look at how you are running your office and doing your documentation and billing to ensure it is in compliance with policy. Ask them if your notes cover the typical documentation items that Gold Star requires. We have heard from some psychiatrists that their electronic medical records include all of these items, but that when a chart is printed from the system (for a reviewer, for example), not all elements the auditor wanted were printed. You may want to make sure—in advance of an actual audit—that the standard items they are looking for are always found in the charts you would pull or print for their review. These standard items include:

1. Presenting problem, reason for the office visit
2. Mental status exam
3. Psychiatric history
4. Special status situations/ suicide risk if appropriate
5. Medical history
6. Developmental/education history for a minor
7. Medications
8. Allergies and adverse reactions.
9. Preventive service/risk screening
10. Documentation of clinical findings/evaluation of EACH visit

Many of these documentation requirements are not surprising and are customary in many physicians' notes. What might surprise members is that a physician may need to use the words "additional treatment is required" or some other clinical language that communicates the need for another visit. Just having your office staff schedule the next appointment is not clinical documentation for continued need for treatment!

So while the urgency to make sure every psychiatrist in Medicaid has a Gold Star audit completed this summer may have abated, it is a good time to re-examine your office practices to determine if your office meets the required thresholds. Scores below 85 percent are considered "preliminary status" and are subject to an annual review. Those scoring 85 percent and above are placed at "preferred status" and are reviewed only every three years.

Our goals for each of our psychiatrists participating in Medicaid is that good care is delivered in the psychiatrist's practice, that the physician is fairly paid on a timely basis, that documentation requirements are standardized and simple to do, and that administrative burdens don't keep our members from participating in this public insurance program. We want all our members to receive "gold stars!"