State of Colorado Department of Health Care Policy and Financing
Claims and Encounter/411 AUDIT

Revised November 23

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411 Audit

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Tips for successfully completing the 411 Audit

Purpose and Process of the 411 Audit

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- For the state to check the accuracy of claims submitted to HCPF for Medicaid services.
- State randomly selects 411 claims/encounters for each RAE in categories they are focusing on.
  - 137 Inpatient institutional services **(E&M coding)**
  - 137 Psychotherapy services **(90832,90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849 or 90853)**
  - 137 Residential services **(H0017, H0018 or H0019)**
- Carelon requests documentation for each claim from the provider and audits according to the state instructions and the Uniform Service Coding Standards (USCS) coding manual.
- State over-audits 30 encounters to double check our results.

Audit Structure – Inpatient Services

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- The 411 audit asks for responses in 12 areas.
  - Items 1 to 5 have a yes (1) or no (0) response.
  - Items 6 to 10 allow the auditor to enter data. The auditor is asked to enter what the data SHOULD BE if it is inaccurate or doesn't match between the documentation and the encounter.
  - Item 11 asks for what E&M Guideline version was used.
  - Item 12 is comments. The auditor should explain any score of 0 or make other comments relevant to the documentation.

Audited Elements

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- **Primary Diagnosis Code** – Auditor is checking the encounter for the correct primary diagnosis code.
- **Revenue Code** – Auditor is checking the encounter for the correct revenue code.
- **Discharge Status** – Auditor is checking the encounter for the correct discharge status.
- **Service Start Date** – Auditor is checking the encounter for the correct start date.
- **Service End Date** – Auditor is checking the encounter for the correct end date.
- **Documented Diagnosis Code** – Auditor enters the correct diagnosis code if present in the supporting documentation.

Audited Elements…Continued

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- **Documented Diagnosis Code** – Auditor enters correct primary diagnosis if present in the supporting documentation.
- **Documented Revenue Code** – Auditor enters the correct revenue code if present in the supporting documentation.
- **Documented Discharge Status** – Auditor enters the correct discharge status if present in the supporting documentation.
- **Documented Service Start Date** – Auditor enters the start date of service from the documentation.
- **Documented Service End Date** – Auditor enters the end date of service from the documentation.
- **E&M Guidelines Version** – 1 = 1995 version of Evaluation and Management Services documentation Guidelines or,
  2 = 1997 version of Evaluation and Management Services documentation Guidelines or,
  3 = 2021 version of Evaluation and Management Service Documentation Guidelines or,
  4 = 2023 version of Evaluation and Management Service Documentation Guidelines
  5 = Does not apply
- **Comments** – Auditor explains any item that did not meet standard.

Audit Structure – Psychotherapy and Residential Services

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- The 411 audit asks for responses in 19 areas.
  - Items 1 to 10 have a yes (1) or no (0) response.
  - Items 11 to 17 allow the auditor to enter data. The auditor is asked to enter what the data SHOULD BE if it is inaccurate or doesn't match between the documentation and the encounter.
  - Item 18 asks for what USCS Coding Manual version was used.
  - Item 19 is comments. The auditor should explain any score of 0 or make other comments relevant to the documentation.

Audited Elements…Continued

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- **Encounter Service Category or Program Category** - Auditor is checking that the 2-letter Program category for the service is correct in the claim and it is an eligible category for the service provided.
- **Encounter Units -** Auditor is checking the calculation of units for the type of service provided, applying the +/- 7 minutes variation allowed.
- **Service Start Date -** Auditor is checking that the start date of the service is the same in the documentation as in the claim.
- **Service End Date -** Auditor is checking that the end date of the service is the same in the documentation as in the claim.

Audited Elements…Continued

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- **Documented Population -** Auditor is checking that the member receiving the service is among the eligible population for that service.
- **Duration -** Auditor is checking that the duration of the service falls within the allowed range for that service (per unit or per diem). The auditor should calculate the duration in minutes and write it down.
- **Staff Requirements -** Auditor is checking that the staff providing the service has credentials that are on the eligible provider list for that service.

Audited Elements…Continued

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- **Procedure code -** Auditor records the procedure code of the encounter if it is accurate OR records what s/he thinks the code should be if it is not accurate. Auditor records NA when there is not enough information to make a decision about the code.
- **Documented E&M Procedure** Code-For psychotherapy cases with a documented procedure code of 90833, 90836, or 90838, the primary E&M procedure code associated with the psychotherapy service in the supporting documentation
- **Diagnosis code -** Auditor records the diagnosis if it is accurate in the claim OR records what the documentation says is the correct diagnosis if it doesn't match the claim.
- **Place of Service -** Auditor records the place of service in the claim if it is accurate OR records what the documentation says is POS if it doesn't match the claim.

Audited Elements…Continued

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- **Units -** Auditor records the number of units if they were accurate in the claim OR records the number of units that should have been on the claim if they are inaccurate.
- **Start Date of Service** - Auditor records the date as given on the claim if it matches the documentation OR records the date in the documentation when it doesn't match.
- **End Date of Service -** Auditor records the date as given on the claim if it matches the documentation OR records the date in the documentation when it doesn't match.

Audited Elements…Continued

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- **USCS Version Used -** Encounters/claims selected for audit may fall in the effective dates of different USCS versions, so the auditor states which version was applied in auditing this encounter.
- **Comments -** Auditor writes down duration in minutes and explains (in detail) any item that did not meet standard.

Areas for Attention

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- **Diagnosis**
  - Difficulties arise when the diagnosis is not printed on the progress note itself. A diagnosis in the psychiatric evaluation or the patient face sheet may not match what was submitted in the claim. We also have to count it as an error when the complete number of digits in the diagnosis is not in the claim (e.g., F31.3 vs. F31.30 or F31.31).
    - Most errors were found with discrepancy between diagnosis on the record and diagnosis in the encounter.
      - It is recommended the diagnosis is printed on every progress note to avoid discrepancies.
      - If additional diagnoses are made during the course of treatment, please be sure to include this in the notes.

Areas for Attention…continued

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- **Place of Service**
  - There is confusion between OFFICE as POS (code 11) or CMHC (code 53). Office should be used by private providers and CMHC by mental health centers. OTHER POS (code 99) is appropriate for service locations in the community. Telephone is usually thought of as a mode of delivery rather than a place of service, but use of Code 02 or 10 for telehealth is acceptable. Please note, 02 should be used for telehealth provided other than in member's home or 10 when telehealth provided in the members home (refer back to the USCM)
    - Most errors occurred with use of Office (11) and CMHC (53).
      - MHC should be coded as 53
      - Independent providers should use code 11
      - Please be sure the code is used throughout the documentation to maintain consistency.

Residential Duration Issue

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- Residential services use per diem procedure durations, and in the past we considered a case to have “passed” the *Duration* element if the medical record documentation supported the patient’s treatment in the facility on the specified date, even when an EMR field for duration listed a lesser amount of time.

- 411 Audit, HCPF has confirmed that RAEs may consider all documentation when evaluating a per diem service, rather than only looking at an EMR duration field. Please use the *Comments* element to record your RAE’s specific approach for cases in which the medical record documentation may support different interpretations.

Areas for Attention…continued

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- **Units**
  - Most errors were from a miscalculation of units for the service.
    - Be sure to refer to the Uniform Service Coding Standards Manual to determine if a unit is encounter based or time based.

- **Minimum Staff Requirements**
  - Most errors were from missing information concerning staff credentials meeting USCS standards.
    - Be sure to refer to the Uniform Service Coding Standards Manual to determine required credentials for each service.
    - Be sure the providers credentials are documented in the chart.

Questions

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- Please contact Jeremy White or Courtney Hernandez in the Carelon Behavioral Health Colorado Quality Department for questions.
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