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OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT
05609-1001

August 20, 2019

Mr. Shay Totten
shay@burlingtontelecom.net

Re: Public Records Request

Dear Mr. Totten,

I write in response to your request for public records under the Vermont Public Records Law, 1 V.S.A. §§ 315032. I respond to each of your requests below.

- **A copy of the winning RFP response and the name of the firm that is conducting the third party review.**

The Brattleboro Retreat issued an RFP and hired the third-party reviewer. The Office of the Attorney General ("AGO") does not have a copy of the winning response. PCG Health conducted the review.

- **Results of the external assessment of the Brattleboro Retreat as outlined in the Settlement Agreement.**

A copy of the PCG Health's external review (previously provided by email) is enclosed.

- **The list of payments made by, or to, the Retreat from Medicaid – both state and federal – as a result of the AGO's review of financial and accounting errors related to Medicaid billing.**

There are no responsive records. There were no payments in either direction that resulted from the AGO's investigation of the Retreat's Medicaid billing related to Mr. Joseph's allegations. As noted previously, the AGO referred the matter to the Program Integrity Unit at the Department of Vermont Health Access to pursue administrative recoveries, if appropriate.

- **All correspondence, written and electronic, and including all attachments, between the AGO and the Brattleboro Retreat, its employees, outside contractors, or fiscal and legal agents of the Retreat regarding post-Settlement compliance and review since the signing of the Settlement Agreement – this should include all quarterly reports spelled out in the Agreement.**

All responsive documents are enclosed. The AGO is not involved in monitoring compliance with the specific compliance measures in the MOU. As a result, responsive records are limited.

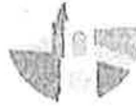
- **All correspondence, written and electronic, and including all attachments, between the AGO and the Brattleboro Retreat, its employees, outside contractors, or fiscal and legal agents of the Retreat specifically regarding the amount owed to Medicaid by the Retreat.**

  There are no responsive records. See response to request No. 3.

Please let me know if I can be of further assistance.

Sincerely

Steven J. Monde
Assistant Attorney General
Steven.Monde@Vermont.gov
802-828-5518



Brattleboro Retreat
MENTAL HEALTH AND ADDICTION CARE

RECEIVED
FEB 07 2019
DEPARTMENT OF VERMONT
HEALTH ACCESS

February 4, 2019

Mr. Al Gobeille, Secretary
Agency of Human Services
280 State Drive
Waterbury, VT 05671

Mr. T. J. Donovan, Jr.
Vermont Attorney General
109 State Street
Montpelier, VT 05609

RE: PCG Health Report of Findings and Recommendations

Dear Secretary Gobeille and Attorney General Donovan:

In accordance with the terms of the MOU signed on June 28, 2018 by each of you and the Brattleboro Retreat, enclosed please find the Report of Public Consulting Group's third-party review. We would be happy to discuss this document with you further if you wish. We look forward to continuing to work closely with you throughout the duration of the memorandum period.

Sincerely yours,

Elizabeth R. Wohl

cc: Stephen Odefey, General Counsel at Department of Vermont Health Access

1 Anna Marsh Lane | PO Box 803 | Brattleboro, VT 05302 | www.brattlebororetreat.org
1.800.RETREAT (1.800.738.7328) |

The Brattleboro Retreat

Systems Review of Billing, Coding, and Revenue Cycle Practices

Report of Findings and Recommendations
State of Vermont
Department of Vermont Health Access
January 2019

PCG | Health
Public Focus. Proven Results.™

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INTRODUCTION

The Brattleboro Retreat (Retreat) is a non-profit psychiatric facility located in Brattleboro, VT and is one of the oldest and most prestigious psychiatric providers in the U.S. the Retreat provides comprehensive psychiatric and substance abuse services in outpatient, partial hospitalization, and inpatient settings to residents of Vermont and neighboring New Hampshire and Massachusetts.

In recent years, the Retreat has significantly strengthened its working relationship with the state's Department of Vermont Health Access (DVHA) and Division of Mental Health (DMH) to provide psychiatric services to an increasing number of state Medicaid recipients. the Retreat's payer mix reflects these changes, with nearly 50% of net inpatient revenues coming from Vermont Medicaid patients in the most recent fiscal year.

Over the past two years, the Retreat has made improving the revenue cycle a significant organizational priority. Through a joint Memorandum of Understanding with the state of Vermont, the Retreat agreed to commission a comprehensive, independent review of revenue cycle and coding processes, particularly as it relates to Medicaid billing, and agreed to share the results of this review with the state and representatives of DVHA and DMH.

In September 2018, the Retreat contracted with Public Consulting Group (PCG) located in Boston, MA to perform this review of revenue cycle and coding processes. The requirements for this review included:

1) A review of the Retreat's business practices and procedures related to its Medicaid billings and claims, including, but not limited to the Retreat's financial management and accounting systems, procedures, and internal controls.

2) A review of the Retreat's billing and coding systems, practices and procedures relating to claims submitted to Vermont Medicaid program, staffing and training (including, but not limited to, the operation of the billing system, the process by which claims are coded, safeguards to ensure proper coding, claims submission and billing; and procedures to identify and correct inaccurate coding and billing). This shall include an examination of a randomly drawn sample of Medicaid claims submitted by the Retreat within the three-month period immediately prior to the Effective Date.

3) No later than thirty (30) days after it completes its review, the Reviewer shall provide a written report of its Systems Review containing its observations and conclusions, and making recommendations either for additional investigation, or for improvements to the Retreat's systems, processes, staffing, and training. The Report will be shared with the Retreat and the Secretary of the Agency of Human Services ("AHS") and the Office of the Attorney General.

Methodologies

PCG conducted the review in five (5) primary phases. These were:

PCG Approach	
Ref #	**Description**
Phase 1	Initial kick-off and data collection
Phase 2	Conduct a financial and operational performance assessment
Phase 3	Medical coding and compliance assessment
[illegible]	Onsite revenue cycle operations assessment
Phase 5	Final Report of Findings and Recommendations

Figure 1 – PCG's approach to performing the independent review of revenue cycle and coding processes

PHASE 1 – INITIAL KICK-OFF AND DATA COLLECTION

PCG conducted an introductory kick-off meeting via conference call and presented the Retreat with a work plan including timelines, and the approach for our review. PCG also submitted a detailed data request to the Retreat. This included payment and denial data from the billing system, policies and procedures, and various management reports. PCG collected and reviewed the materials and data sent by the Retreat

PHASE 2 – CONDUCT A FINANCIAL AND OPERATIONAL PERFORMANCE ASSESEMENT

Since moving from an external billing provider to bringing the full RCM back in-house the Retreat has implemented protocols that monitor the RCM from patient intake to account close-out. To validate the financial process PCG requested several data elements from the Avatar Electronic Health Record and Practice Management System to review financial and operational statistics. This did prove a difficult task due to the configuration of the Avatar system. Currently only payment and denial data can be retrieved from the Relay Health clearinghouse system currently in use. PCG utilized this data to perform a payment and denial analysis. The results of this analysis found that the Retreat did not have any serious or unusual denials and that the Retreat has a solid denial review and follow-up process that is continuously being updated as the team uncovers high-volume or high-dollar denials.

PHASE 3 – MEDICAL CODING AND COMPLIANCE ASSESSMENT

PCG performed a coding and compliance assessment on fifteen (15) randomly selected medical records. The PCG auditor is an AAPC Certified Professional Coder, an AAPC Certified Professional Coder Instructor, and an approved AHIMA ICD-10-CM/PCS Trainer. The medical records reviewed in each of the following hospital programs are as follows:

- Inpatient Psychiatric Services (Inpatient) - 5 records
- Partial Hospitalization Program (PHP) - 5 records
- Intensive Outpatient Program (IOP) - 5 records

PHASE 4 – ONSITE REVENUE OPERATIONS ASSESSMENT

PCG sent three (3) consultants to the Retreat and spent three (3) days meeting with key management staff and performing walk-throughs of the revenue cycle operations. This included utilizing a proprietary one hundred sixteen (116) questionnaire focusing on the following key revenue cycle functions:

Hospital Functions

- Admissions and Registration
- Insurance Verification
- Benefit Coordination
- Charge Capture
- Medical Record Documentation
- Importing Charges to Practice Management System

Billing Office Functions

- Claim Submission Processes
- Claim Rejection Processing
- Outstanding Claim Follow-Up
- Payment Posting
- Denial Follow-up and Appeals
- Provider Credentialing
- Reporting
- Systems

PHASE 5 – FINAL REPORT OF FINDINGS AND RECOMMENDATIONS

Upon completion of the assessment phases, the PCG project team formally presents our findings and recommendations (in this document).

EXECUTIVE SUMMARY

Overview

Management has a strong understanding of the issues and challenges they have been facing since bringing the billing component back in-house. Their internal improvement process was to identify key function areas and practices in need of improvement. The Retreat formed work groups to create project plans and special projects to assess and implement the necessary improvements. As with all process changes, many implementations are ongoing. In this Executive Summary PCG addresses the concerns listed within the Memo of Understanding that precipitated this assessment.

In summary, PCG has determined that the Retreat has implemented compliance measures and protocols to mitigate the risk of erroneous billings and billing practices and continues this process improvement within their daily operations. The results of the assessment show that the Retreat has no major compliance issues. There are areas needing further improvement; however, these improvements are not major and are not new. The Retreat is aware, and they have begun to address them. This sections that follow provides a more detailed accounting of PCG's assessment.

GOAL ONE

1) *A review of the Retreat's business practices and procedures related to its Medicaid billings and claims, including, but not limited to the Retreat's financial management and accounting systems, procedures, and internal controls.*

Medicaid Billing and Claiming Business Practices and Procedures

PCG uses The Office of Inspector General compliance guidelines and its seven key guidelines as a starting point for all assessments. Having an understanding and implementing protocols based on the OIG's guidelines ensures a strong foundation for any facility. PCG outlines these guidelines below to provide an understanding of the background and methodology of our assessments.

The Office of Inspector General (OIG), U.S. Department of Health and Human Services has developed a series of compliance guidelines for healthcare organization to prevent fraud, abuse and waste in the delivery of services and "to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements". The guidelines and supportive resources can be found at the following site: https://oig.hhs.gov/compliance/compliance-guidance/index.asp

These guidelines provide the following seven key guidelines to meet the stated objectives:

1. Implementing written policies, procedures and standards of conduct
2. Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected offenses and undertaking corrective action

The guidelines can also be considered a best practice guideline to assess health care organizations. While all of these guidelines are important and work in unison to promote a high level of compliance, three of these seven guidelines serve as fundamental building blocks to a strong revenue cycle management operation. The fundamental building blocks are:

- *Implementing written policies and procedures*, which documents the integrated and efficient processes of data collection, charge generation, claim production and revenue collection activities among other essential business activities of a health care operation

- *Conducting effective training and education*, which can use the written policies and procedures as their basis to communicate the best practice processes to staff and to sustain strong operational and management processes over time

- *Conducting internal monitoring and auditing activities*, which reviews key functions of service documentation and claiming operations to measures performance against statutory, regulatory and program requirements as well as best practice methodologies.

Financial Management and Accounting Systems

Based on PCG's proprietary assessment tool, a comprehensive review of the RCM process, PCG did not find any major compliance issues surrounding their financial management and accounting systems or their related operational processes and protocols.

The Retreat uses Avatar as their Electronic Health Record (EHR) and Practice Management System (PM). While Avatar was created for outpatient psychiatric care, the Retreat has worked with their software vendor and an internal IT team to update and create SQL based ad-hoc reports and monitoring tools to improve compliance in areas of patient intake, charge capture, coding, and billing processes.

- Patient Access (Front End)
- Charge Capture and Coding (Intermediate)
- Patient Accounting (Back End)

Along with open discussion, PCG used a proprietary revenue cycle management assessment tool. PCG used the results from this tool to determine the status of the Financial Management and Accounting Systems and their associated processes, procedures and internal controls. The areas were assessed and given rates that would fall in the categories listed below.

- Meets Best Practice
- Slight Improvements Needed
- Moderate Improvements Needed
- Significant Improvements Needed
- Does Not Meet Best Practice
- Non-Applicable

BILLING PROCEDURES AND INTERNAL CONTROLS

As stated in the Financial Management and Accounting Systems section above PCG did not find any major compliance issues within the billing procedures and internal controls.

The Retreat's management team has a strong understanding of the issues and challenges they are facing, they have ensured that the procedures, controls, and protocols surrounding the claiming process touches both the system and the teams that use it. They have already identified several key function areas and practices needing improvement and have implemented multiple changes. However, there are areas where improvements can still be made.

The following highlights key areas where best practices are met and areas where improvements can still be made.

MEETS BEST PRACTICE

PCG reviewed Goal One across the main areas of the Retreat's revenue cycle. These include Patient Access, Charge Capture and Coding (including HIM), and Patient Accounting (which includes the processes of claim creation to account closure). Processes found in this section meet or exceed best practice requirements. These include:

1) **Patient Access**
   a. The registration process includes all typical standard forms (PHI Disclosure, Privacy Notice, Consent to Treat, etc.)
   b. Patient insurance information and eligibility is verified during the registration process and prior to services being rendered
   c. The insurance card is electronically scanned into the medical record
   d. There are secure control processes in place for cash payments made during the registration process
   e. Patient's with no insurance receive assistance to determine eligibility for Medicaid and the application process

2) **Charge Capture and Coding**
   a. The Avatar system is routinely updated with new coding edits and changes
   b. Most encounters are closed in the E.H.R. and transferred to the PMS by the end of the same day
   c. The Utilization Review team has a daily process to review new admissions and current discharges to ensure appropriate or necessary certifications and medical necessity
   d. The Utilization Review team reviews documentation to ensure recertification for treatment and ongoing active treatment
   e. The HIM team reviews documentation for completeness and crosswalks it to the diagnostic code selection reviewing for potential physician queries for clarification of unspecified diagnostic codes and appropriate sequencing

3) **Patient Accounting**
   a. There are control processes in place for monitoring payer contracts and provider credentialing
   b. Claims are submitted electronically through a claiming clearinghouse
   c. Claims are submitted on a weekly basis
   d. Rejected claims are corrected and resubmitted prior to the next claim submission date
   e. The department uses standardized notes in the system when documenting work efforts made for the claim
   f. Payer websites are used to check the status of outstanding claims and telephone calls to the payer are made when necessary
   g. There are secure control measures in place for handling cash and checks received

IMPROVEMENTS NEEDED

The following items were designated as compliant, but improvements would benefit the Retreat in their on-going work efforts towards a complete review of their accounting practices since bringing claiming back in-house:

1) **Patient Access**
   a. Discuss with patient or patient's representative their likely insurance coverage, co-pays, and deductibles prior to rendering services
   b. Improve the system configuration and monitoring tools to provide a better control process to link self-pay payments to charges in a timelier manner
   c. Improve current Policies and Procedures to a more standardized format, to include word or excel tables directly into the main policy

2) **Charge Capture and Coding**
   a. Implement an auditing and monitoring process to ensure that services are moved from draft to final in the E.H.R. on the rendered service date
   b. Change Avatar system configuration so that all services are entered directly into Avatar eliminating the need for scanning or manual data entry
   c. Provide additional training to all team members in all areas more frequently than yearly, provide on-board training to new hires and residents within a reasonable timeline as determined by the Compliance team
   d. Training should cover coding, payer reimbursement, updates to compliance plan, and policies and procedures as necessary

3) **Patient Accounting**
   a. Review the auditing and monitoring process of outbound claims to be concurrent and completed for both claims that produce system alerts and those with only warnings
   b. Create a claim batch pre-submission report if the system does not provide a comprehensive report or if the standard system report does not provide the appropriate data
   c. There should be a formal queue process for claiming specialists to work open claims, the Retreat is reviewing outside software that will provide this functionality
   d. Create efficiencies for claiming specialists, again through a queue process, to ensure that all claim lines are reviewed for an account at one time; this relates to item 'c' above and will be rectified when the software is implemented
   e. Provide training for all members of the department regarding all phases of the RCM and claiming process. The Retreat has begun to implement weekly meetings that are showing a positive effect on the bottom line
   f. Review the software program for efficiencies not implemented regarding the payment posting process, currently some efforts are manual and duplicative due to the constraints of the software and its configuration, the Retreat already has a project plan in place to augment the system
   g. Routinely review payments to ensure payer compliance with fee schedules, the Retreat has implemented a special project to review fee schedules and payer contracts
   h. Increase online access to individuals in care and / or their representatives for account balance payments to be performed by check or credit card

ADDITIONAL OPPORTUNITIES TO IMPROVE COMPLIANCE

The following items are general areas that PCG routinely suggests to all clients that should be reviewed for current use and / or appropriate implementation, considerations for potential team member augmentation, and realization of improved compliance standards and outcomes.

1) **Patient Access**
   a. Review the use of the Medicare Advanced Beneficiary Notice (ABN)
   b. Review the use of a Health Insurance Denial Form for clients with other types of insurance
   c. Review the self-pay billing / statement process

2) **Charge Capture and Coding**
   a. Review the use of HIM / UR tracking tools to ensure documentation compliance for services and diagnostic statements
   b. Review the use of HIM / UR tracking tools to ensure documentation compliance for length of stay certifications, medical necessity, and active treatment
   c. Review the auditing and monitoring program to ensure that all programs are audited at least yearly, preferably quarterly, and that one time per year an external audit is performed by a third party
   d. Ensure that results of auditing and monitoring reviews are disseminated to all necessary clinical and support teams, include one-to-one training for outliers
   e. Ensure yearly compliance training, additional trainings can include
      i. Common coding errors, diagnostic code selection and sequencing

3) **Patient Accounting**
   a. Review the system for claim rejection reporting or create a more robust application that allows for information to be tracked and monitored in an automated fashion rather than the current manual tracking methodology
   b. Ensure all findings are disseminated to clinical and support staff to ensure immediate and ongoing process improvement via internal vehicles such as memos, internal newsletter, intranet alerts, and other forms of communication
   c. Ensure that high-volume or high-dollar claim rejections are part of the clinical and support staff routine training, at minimum yearly, but provide information in a more immediate manner via methods listed in item 'b' above

4) **Consulting and Training Assistance**
   a. The Retreat has hired a consultant who has provided significant assistance in the areas addressed within this report and as required by the Medicaid assessment. The consultant has implemented training based on updates to all the special projects that are part of the overall process improvement initiative implemented by the Retreat
   b. Additionally, PCG often finds that adding training team member as a facility employee provides more immediate and timely updates to be disseminated across the hospital and its departments
      i. This person would be responsible for creating staff training programs and documentation and performing routine training classes for staff
      ii. This person would work closely with Patient Accounting and Medical Records to understand the bulk of the billing, coding, and documentation errors so education documentation could be created and disseminated to hospital staff as necessary

5) **General**

a. Policies and Procedures and Internal Controls

i. PCG reviewed several written policies and procedures and internal controls. It has only been one (1) year since the Retreat brought the claiming back in-house, with any new implementation there are growing pains and areas of needed improvement. The Retreat has a solid understanding of the need for internal controls and for official, well-written and organized Policies and Procedures. This work has begun. PCG recommends the following work plan to ensure that the Retreat maintains its compliance by instituting the following short- and long-term goals.

SHORT TERM

1. Consolidate all written policies and procedures into a centralized location (Shared Drive)
    a. Develop coordination strategy to maintain over time
    b. Use standardized format and review processes
    c. Identify, describe, illustrate, and reference additional procedure data bases locations

2. Reorganize existing policies and procedures into functional area and function (e.g. Patient Access – Registration)

3. All Policies and Procedures should include
    a. Ownership of each stated procedure (i.e. list the "player")
    b. Internal control reports / processes to monitor completion or open items

4. Continue to support and develop the Revenue Cycle Committee as a central component of revenue cycle improvement process, including
    a. Problem identification and resolution
    b. Organizational collaboration
    c. Integrated policy and procedure development and documentation

5. Develop impact analysis and change approval processed through the Revenue Cycle Committee or like organization to include
    a. IT impact
    b. Staffing impact
    c. Work flow impact
    d. Other operational impacts

6. Provide high level process flows sequencing of processes with time lines
    a. May be multiple as sequencing may different based on program or situation (acute vs. planned inpatient admission)
    b. Include ownership and oversight summary matrix
    c. Identify and document policy and procedure gaps

7. Evaluate the creation of a project staff team to accomplish these goals and develop global, standardized approaches to include
    a. IT (System Configuration and Functionality and Work Flow)
    b. Lead operations team members
    c. Outside consultants

8. Develop corrective action and resource plan to review and update policies and procedures for accuracy and current / best practice
    a. Some policies and procedures have just passed their review date
    b. Update based on comprehensive workflow process of the entire revenue cycle process

LONG TERM

1. Use policies and procedures as the baseline for Training and Education
    a. Supports compliance

GOAL TWO

2) *A review of the Retreat's billing and coding systems, practices and procedures relating to claims submitted to Vermont Medicaid program, staffing and training (including, but not limited to, the operation of the billing system, the process by which claims are coded, safeguards to ensure proper coding, claims submission and billing; and procedures to identify and correct inaccurate coding and billing). This shall include an examination of a randomly drawn sample of Medicaid claims submitted by the Retreat within the three-month period immediately prior to the Effective Date.*

Medical Record Review Methodology

PCG's findings in the Medical Record Review did not reveal any major compliance issues. PCG reviewed Goal Two across the Retreat's billing and coding systems, including the practices and procedure relating to claims submitted to the Vermont Medicaid program. The review took under consideration compliance obligations outlined within the MOU, including PNMI claims, Medicaid claims, Timely Filing, Usual and Customary Rates, Medicaid as the payer of last resort, and provider enrollment. As with the other areas reviewed, opportunities for improvement were found, and these are already part of the Retreat's overall process improvement project. PCG details the medical record review methodology and their findings in the sections below. Additionally, the specific areas of concern are folded in to provide a comprehensive review and understanding of compliance surrounding the billing and coding systems and the individual MOU compliance obligations.

The Medical Record Review included both a documentation and financial audit. Documentation was reviewed to ensure that services were supported, and all requirements of the individual programs were met. The three programs reviewed were Inpatient Hospital (IH), Partial Hospital Program (PHP) and Intensive Outpatient (IOP). Five (5) medical records from each program were reviewed to determine appropriateness of the documentation and completeness of the record using Medicare and Medicaid requirements. The Retreat's Director of Health Information and Privacy assisted with clarifying any questions that may have risen from reviewing the documentation.

Financial records were also reviewed using ledger data (pre-and post-payment), copies of claim forms (CMS 1500 and 1450), and EOBs as necessary. The Retreat's Director of Claiming assisted with clarifying any questions that may have risen from reviewing the financial documents.

General Observations and Findings

The observations and recommendations found in this section are high level and summarize the HIM / Financial departments and their processes on a whole rather than by the individual programs. Findings in this section are general in nature and can be used to strengthen the overall RCM process. Specific program findings are listed where appropriate to highlight immediate concerns that can be corrected quickly.

PROVIDER DOCUMENTATION AND CODING PROCESS OVERVIEW

All Programs

Documentation completed by providers was sound, completed timely and supported the services rendered in all cases reviewed. PCG found that providers are documenting appropriately, ensuring that service time is documented, related treatment goals are indicated, and individual in care participation is well documented.

All medical record notes are reviewed to ensure all they have been electronically signed and moved from a draft version to a closed and final version. The Avatar system does not allow a bill to be produced until all notes are electronically signed and in a closed and final status.

Throughout the course of the length of stay and upon discharge, the system is updated with services, reviewed by the Utilization Review and Health Information Management support team to ensure completeness of the record, that it supports the rendered services, and if any physician queries are needed that they are closed in a timely fashion. The process of admission to claim submission and account closure is documented in the Revenue Cycle Management process below.

FINANCIAL PROCESS AND DOCUMENTATION OVERVIEW

The Retreat has solid documentation and the provider documentation fully supports the services rendered. The Avatar configuration poses an issue to the Retreat's reimbursement due to inappropriate configurations that is leaving monies on the table, potentially causing a loss of revenue. PCG did not find any instances of overpayments from any payer including Medicaid. PCG did determine that the Avatar configuration may be understating the correct units in the Partial Hospital Program. PCG has suggested process improvements to mitigate this risk and they can be found in the "Additional Opportunities to Improve Operational Compliance" section below. The Retreat is aware of findings outlined below and has set up a special project to ensure that any automated processes surrounding the revenue and service code linking or "roll up" process is dropping the correct dollar values. This will allow the Retreat to optimize revenue by reviewing fee schedules across all payers. Additionally, the Retreat is internally reviewing the payment posting process to ensure that fee schedule amounts, contractual adjustment, and write-offs are reviewed to determine correct payments from all payers. Details of the Financial Process and Documentation are outlined by each program below.

Inpatient, IOP and PHP

During the review PCG determined that the Retreat may not be receiving all appropriate funding or has had a per diem rate increase that is not reflected in the system. This is due to a system configuration that is already under review to determine fee schedule calculations, adjustments, and alerts. This could have a potential of significant monies not being realized by the Retreat.

Inpatient

As previously stated, Inpatient lengths of stay are appropriately documented and support the services rendered. The financial reimbursement for the Inpatient lengths of stay are based on a per diem and the financial review found no issues with the claiming process or the reimbursement made to the Retreat. The Avatar system has been set up to ensure that all services submitted to the Avatar system and linked to the appropriate Revenue and Service Codes and includes a process to calculate and post the billed amount.

Intensive Outpatient Program

Like the inpatient program, Intensive Outpatient reimbursement is per diem based. Documentation fully supported the services rendered. The financial review found an issue with the Avatar fee schedule posting process. Avatar's configuration links services to the correct revenue and service codes; however, it often increases the billed amount based on units of services. This is a known issue and is currently being corrected within the system. However, this did bring to light that the Retreat is not being fully reimbursed across all payers. It appears that, with some payers, their per diem charge rate is significantly lower than their allowable reimbursement amounts. This could have a potential of significant monies not being realized by the Retreat.

Partial Hospital Program

The Partial Hospital Program is based on units and specific services codes. The documentation for this program fully supports the services rendered. The financial review found an issue with The Avatar configuration and how it determines billable units. The system appears to be correctly linking the appropriate revenue and service codes, while accurately reporting gross charges, it appears to be understating service units. Again, this could have a potential of significant monies not being realized by the Retreat.

REVENUE CYCLE MANAGEMENT (RCM) PROCESS AND DOCUMENTATION OVERVIEW

Registration

All forms needed for claiming should be scanned before discharge and be available in the Avatar system for UR, HIM, and Financial team members to ensure that the length of stay is ready and appropriate to bill.

Registration should begin the batch process either on a hard copy form or within the Avatar queue checking that the forms are signed, dated, and in the system and available for review.

Utilization Review (UR)

UR reviews services for active treatment and certifications, including medical necessity. UR also reviews the documentation for timeliness and completeness.

If a batch form is used it would be beneficial for UR to post the dates where the certifications are found as they are embedded in the general documentation, there is no separate certification forms for the inpatient stays. This would be helpful in audit situations to show where the documentation was found for the original certification and that the recertification was done in a timely manner.

Health Information Management (HIM)

HIM ensures that all diagnostic codes are appropriate and sequenced correctly. HIM would complete the diagnostic review is complete the batch control form or queue would be updated indicating to the financial team that the length of stay is ready for billing.

The updates to the diagnostic list are completed within Avatar, the Retreat is currently looking at an improved configuration that will allow for a more automated process for physician queries and updates to the diagnostic codes that HIM reviews and finalizes before a claim is dropped for processing and submission.

Financial (Patient Accounts)

The financial team, once receiving the claim data should review the batch control and generate the claim. If there are edits, alerts, or needed overrides to produce a clean claim this should be noted on the control sheet to determine future or further research that may be needed.

Additionally, the queue should not be closed until payment is received and the account is a zero balance. Any payment anomalies should be noted, again to keep track of the need for future or further research.

MEETS BEST PRACTICE

PCG reviewed Goal Two across the Retreat's billing and coding systems, including the practices and procedure relating to claims submitted to the Vermont Medicaid program. The review took under consideration compliance obligations outlined within the MOU, including PNMI claims, Medicaid claims, Timely Filing, Usual and Customary Rates, Medicaid as the payer of last resort, and provider enrollment.

1) **Billing System**
   a. Avatar meets the needs for the Retreat and has been configured for claim production based on the different programs
   b. Avatar meets the needs for the Retreat for medical record documentation and the templates are routinely reviewed to meet necessary documentation requirements
   c. Avatar is appropriately configured for the various roles and responsibilities and access levels for all Retreat team members in all areas

2) **Coding Processes and Medical Record Review (includes Provider Documentation)**
   a. Provider Documentation
      i. All Programs
         1. All documentation was sound and supported all services in all cases reviewed
         2. All documentation included service time, related treatment goals, and individual in care participation
         3. Charts / Medical Records are reviewed in the Avatar system for appropriate completion ensuring timely filing of all lengths of stay in a discharged status
         4. The Retreat has processes in place to ensure every provider is electronically signing all documentation and moving the document from draft to final to facilitate timeline claiming
   b. Utilization Review and Coding Processes
      i. All Programs
         1. The Avatar billing system does not allow for service data to move to claim production until all notes for an account / length of stay are electronically signed and in a closed and final status
      ii. Inpatient Program
         1. Utilization Review team members review the daily census to ensure medical necessity, active treatment, and discharge processes
         2. Health Information Management (HIM) team members review diagnostic codes and documentation to determine the need for physician queries to ensure that services are appropriately supported by the diagnosis codes
      iii. Intensive Outpatient Program
         1. HIM team members review diagnostic codes to determine the need for physician queries to ensure that services are appropriately supported by the diagnosis codes
         2. Utilization Review team members review processes of individuals in care that move from the inpatient program to the Intensive Outpatient Program to ensure medical necessity is met
      iv. Partial Hospital Program
         1. HIM team members review diagnostic codes to determine the need for physician queries to ensure that services are appropriately supported by the diagnosis codes
         2. Utilization Review team members review processes of individuals in care that move from the inpatient program to the Intensive Outpatient Program to ensure medical necessity is met

3) **Financial Accounting (includes PNMI and Medicaid Claims, Timely Filing, Usual & Customary Rates, Medicaid as Payer of Last Resort, Provider Enrollment)**
   a. The Financial review showed that the Retreat is meeting best practice in the following areas
      i. PNMI Claims:
         1. The Retreat has processes in place that ensure that remittance advices ensuring account reconciliation via timely posting, appropriate denial follow-up, and timely appeals and / or corrected claim submission when needed
      ii. Medical Claim Error Rate:
         1. PCG did NOT find evidence of any overpayments, putting the overpayment error rate at 0%
         2. The Retreat has an internal process in place with Utilization Review to ensure timely receipt of prior authorizations
         3. The Retreat has an internal process in place to review received payments to ensure proper payments are being received
         4. The Retreat has an internal process in place to review documentation is appropriate and all coding supports the services rendered
      iii. Timely Claims Filing:
         1. The Retreat has an internal process in place to ensure time filing of lengths of stay through the stay and upon discharge
      iv. Usual and Customary Rate
         1. The Retreat has configured the billing system with their usual and customary rates
      v. Billing Primary Insurance before Medicaid
         1. The Retreat has an intake process that ensures all insurance companies for any individual in care are prioritized appropriately ensuring that Vermont Medicaid is the payer of last resort
         2. The Retreat billing staff routinely reviews this data to ensure that claims are submitted to the appropriate payer before the claim is submitted
      vi. Provider Enrollment
         1. The Retreat has a dedicated team that ensures all providers are enrolled with all necessary payers, including Vermont Medicaid in a timely fashion and that no services are rendered to a Vermont Medicaid beneficiary

IMPROVEMENTS NEEDED

The following items were designated as compliant, but improvements would benefit the Retreat in their on-going work efforts towards a complete review of their accounting practices since bringing claiming back in-house:

1) **Billing System**
   a. The Avatar billing system should be reviewed to determine appropriate configuration for the following:
      i. Intensive Out Patient
         1. The "roll up" process needs to ensure that the per diem rate is correct for all payers and is not increased based on the number of units / services performed on any given day
            a. The configuration review is already in process and was on the Retreat's project plan at the time of the review
      ii. Partial Hospital Program
         1. The "roll up" process appears to be understating the number or units provided per day to individuals in care
            a. The "roll up" process needs to ensure that the number of units is correctly indicated on the claim form for each service performed on any given day, services need to be delineated between educational and therapy
               i. The configuration review is already in process and was on the Retreat's project plan at the time of the review

2) **Coding Processes and Medical Record Review**
   a. The Avatar medical record module should be reviewed to determine reconfiguration of the health information management teams' entries into the system
      i. The HIM team inputs their findings / updates into the system and to an untrained auditor or reviewer it appears that the information being entered is changing the record, the configuration needs to be updated so that the HIM notes do not appear as if they are part of the medical record documentation
         1. This is a known issue and is already on the Retreat's project plan for correction
   b. The Retreat would gain further support if the UR and HIM team members were more fully supporting the Intensive Outpatient and Partial Hospital Programs, while the coding and billing did NOT find any documentation errors or major billing issues all programs should be part of a general internal audit at least yearly

3) **Financial Accounting**
   a. The billing team appears to silo their payment process, it is suggested that an entire RA is posted, and denials are reviewed; posted to the system and placed into a queue for immediate follow-up rather than the payment posting process being interrupted
      i. This is a known issue in the payment process and the Retreat has already initiated measures to change this process
   b. Routinely review payments to ensure payer compliance with fee schedules, changes in per diem rates, and appropriate payment
      i. The Retreat has implemented a special project to review fee schedules and payer contracts
   c. Routinely review claims to ensure that units (where necessary) and charge values match, it appears that the Avatar system configuration may be understating units and applying charge values that cause the Retreat to be underpaid

i. The Retreat has implemented a special project to review the configuration and its affect on units and charge values to ensure that no monies are left on the table and that the Retreat is paid all the money they are owed

ADDITIONAL OPPORTUNITIES TO IMPROVE COMPLIANCE

The following items are general areas that PCG routinely suggests to all clients that should be reviewed for current use and / or appropriate implementation, considerations for potential team member augmentation, and realization of improved compliance standards and outcomes.

1) **Billing System**
   a. Alerts and Notifications
      i. Determine if Avatar can provide alerts or notifications during the posting process if payers do not pay the fee schedule allowed amount or makes an overpayment; this will allow real time reviews where rates need to be updated, refunds submitted, or corrected claims completed
   b. Queue Process
      i. Determine if Avatar allows for a queue process with alerts and notifications when there are needed processes to be completed or closed to provide automation to a process that is currently more manual in nature

2) **Coding Process and Medical Record Review**
   a. Determine if Avatar allows for a queue process to allow HIM to concurrently review documentation and diagnostic problem lists to promote timely and accurate claiming
   b. Determine if HIM coding update processes are current and that the system configuration allows for real-time input rather than waiting for the provider documentation close out process
   c. Review the use of HIM / UR tracking tools to ensure documentation compliance for length of stay certifications, medical necessity, and active treatment
   d. Review the use of HIM / UR tracking tools to ensure documentation compliance for services and diagnostic statements
   e. Review the auditing and monitoring program to ensure that all programs are audited at least yearly, preferably quarterly, and that one time per year an external audit is performed by a third party
   f. Ensure that results of auditing and monitoring reviews are disseminated to all necessary clinical and support teams, include one-to-one training for outliers
   g. Ensure yearly compliance training, additional trainings can include
      i. Common coding errors, diagnostic code selection and sequencing

3) **Financial Accounting**
   a. Initiate a corrected claim process
      i. Based on the billing system "roll up" issue the Retreat should implement a corrected claim process and determine if the Avatar billing system has a queue process that allows for the claims to be moved through the corrected claim process faster
         1. The Retreat has initiated a corrected claim project plan to retrieve any monies that can currently be realized due to the "roll up" configuration; however, this process should become routine to ensure that the Retreat catches these issues before they become too large and the Retreat cannot be reimbursed due to each individual appeals / correct claims policies for these types of resubmission

CONCLUSION

PCG's assessment has determined that the Retreat has no major compliance issues in any area of their Revenue Cycle Management process. PCG has outlined the areas that would benefit from additional improvements.

The Retreat has a strong understanding of the challenges they are facing. During this assessment PCG noted that the Retreat meets or exceed industry best practices in many areas, and there are instances where improvement is needed. The Retreat has a knowledgeable management team who are working toward the same goals. They have formed various committees to attack areas of concern and continue working toward improving processes and procedures.

Management has identified several key areas for special projects that have already begun or are slated to begin within the next quarter; given the size of the hospital, several of the improvements will take time to implement. The Retreat has already implemented multiple changes that have realized compliance improvements.

Should there be any questions related to the contents of this report, please contact PCG at:

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Manager
148 State Street
Boston, MA 02109
617-717-1250
rdwyer@pcgus.com

www.publicconsultinggroup.com

Monde, Steven

From: Wohl, Elizabeth <ewohl@brattlebororetreat.org>
Sent: Monday, August 13, 2018 6:23 PM
To: Monde, Steven; Odefey, Stephen
Subject: DVHA/Retreat MOU

Gentlemen:
I hope the summer has treated you well. I wanted to check in with you both. We are receiving responses to the RFP we put out for the work contemplated by our MOU. The MOU contemplates that we would identify a reviewer within 60 days and then obtain your consent before engaging the reviewer. I wanted to be sure that we are clear on the process. We intend to make a preliminary selection, and then provide the name of that entity to both of you.
With regard to the Reviewer we choose, what information will you want from us. Will you want to contact them independently? We are fine with whatever process, but I just want to be sure that we are all on the same page.
Secondarily, our 60 days is up on Monday, August 27. Because of vacation schedules, it is going to be challenging for me to pull our whole team together before that date. Could we have until August 31, to identify our reviewer to you?
Many thanks,
Elizabeth
Elizabeth R. Wohl
General Counsel and Chief Compliance Officer
P.O. Box 803
Brattleboro Retreat
Anna Marsh Lane
Brattleboro, VT 05302
(802) 258-6988
ewohl@brattlebororetreat.org

Brattleboro Retreat

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Monde, Steven

From: Wohl, Elizabeth <ewohl@brattlebororetreat.org>
Sent: Friday, August 24, 2018 11:58 AM
To: Monde, Steven; Odefey, Stephen
Subject: Re: DVHA/Retreat MOU

Hello,

Just checking in as I never received a response to this message. I am in California. Monday will be my first day back.

I will do everything I can to get our selection to you early in the week, but we would like the flexibility of having until Friday if necessary.

Please let me know if that is agreeable to you.

Thanks,
Elizabeth

Sent from my iPhone

On 13 Aug 2018, at 3:23 pm, Wohl, Elizabeth <ewohl@brattlebororetreat.org> wrote:

> Gentlemen:
>
> I hope the summer has treated you well. I wanted to check in with you both. We are receiving responses to the RFP we put out for the work contemplated by our MOU. The MOU contemplates that we would identify a reviewer within 60 days and then obtain your consent before engaging the reviewer. I wanted to be sure that we are clear on the process. We intend to make a preliminary selection, and then provide the name of that entity to both of you.
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> Secondarily, our 60 days is up on Monday, August 27. Because of vacation schedules, it is going to be challenging for me to pull our whole team together before that date. Could we have until August 31, to identify our reviewer to you?
>
> Many thanks,
> Elizabeth
>
> Elizabeth R. Wohl
> General Counsel and Chief Compliance Officer
> P.O. Box 803
> Brattleboro Retreat
> Anna Marsh Lane
> Brattleboro, VT 05302
> (802) 258-6988
> ewohl@brattlebororetreat.org

<image001.png>

Monde, Steven

From: Wohl, Elizabeth <ewohl@brattlebororetreat.org>
Sent: Monday, November 19, 2018 9:30 AM
To: Odefey, Stephen; Monde, Steven
Cc: Craig Miskovich
Subject: Retreat external review

Dear Stephen and Steve:

I write to report that Public Consulting Group has completed its on-site visit. Per our agreement, they have 30 days to complete a written report. They did request some flexibility in that 30 days since their visit fell so close to the Thanksgiving holiday. Please let me know if you would allow them an additional 15 days, (only if they need it) to complete the report.

Many thanks,
Elizabeth

Elizabeth R. Wohl
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