2020-2021
Edition

Solano County Department of H&SS
Behavioral Health Division

Mental Health Bureau

UTILIZATION REVIEW

HANDBOOK

Solano County Department of Health & Social Services
Behavioral Health Division – Mental Health Bureau
275 Beck Ave., MS 5-250
Fairfield, CA 94533
Ph: (707) 784-8323 Fax: (707) 427-2774

Rob George, LCSW, QI Manager
Amanda Davis, PsyD, QI Supervisor
Judeth Greco-Gregory, PhD, UR Supervisor

All questions, comments and/or concerns can be sent to:

qualityimprovement@solanocounty.com

Introduction

The Solano County Behavioral Health - Mental Health Quality Improvement Unit is mandated by *California Code of Regulations, Title 9, chapter 11, sections 1810.110(a), 1810.435 (a)(b)(4) and (c)(7), 1840.112, and 1840.314* to review the quality of specialty mental health services provided to our beneficiaries, and to ensure that our county and contract providers meet established standards for authorization of Short-Doyle Medi-Cal services. Part of this mandate is achieved through conducting annual *Utilization Review* (UR) audits of all county and contracted services billed through our current Mental Health billing system.

The Review Period

The review period consists of the two (2) month period beginning three (3) months prior to the month of the audit. For example, the review period for an audit taking place in January would be October and November.

The Utilization Review Process:

Below is a step-by-step description of the utilization review process:

Step 1 – Notification of Audit Date

Ten business days prior to the review, the County Program Supervisor/Manager or Contractor Clinical Head of Service and lead clerical staff will receive an electronic notification. This notification will inform program of the date of the upcoming review and the period that will be covered.

Step 2 – Notification of Medical Records to be Audited

Five business days prior to the review, Quality Improvement will email the County Program Supervisor/Manager or Contractor Clinical Head of Service and lead clerical staff a chart list. The list will consist of at least one chart per provider (and/or a minimum of 5 charts) for which there has been an open case and/or billed services during the review period. These charts will be referred to as the Primary Chart List.

Step 3 – Program Responsibility for Audit Preparation

County Programs:

To prepare for the Utilization Review Audit, program staff should ensure their medical records are in good order and all necessary documents are included in the chart.

- The program should review the chart list emailed five business days prior to the scheduled audit.
- The program should ensure all paper documents with wet signatures are scanned in the electronic medical record. Electronic documents in the medical record are not required to be printed in the hard copy chart for the purpose of this review.
- If paper documents exist in the chart that are in the review period, please **scan** all Assessments, Client Service Plans, or other documents showing current medical necessity as well as other applicable documents to ensure they are easily located in the electronic health record. Refer to audit notification letter for specific instructions.

- Relevant documents include: Face Sheet, Payer Financial Information (PFI), Acknowledgement of Receipt, Consent to Treat (including Telehealth and Email/Text), Medication Consents, Release of Information (ROI), Assessments (including allergy info), Client Service Plans, Diagnosis form, Progress Notes, Group Logs, and other applicable documents showing current medical necessity to cover review period.
  - For Ancillary programs, copies of the above documents from Primary programs should be included for the review.
- Prepare a signature list of all staff including their credentials.
- Please provide applicable group logs and NOBEs for the audit period.
- Only technical revisions may be made at this point (e.g. dates, filing, etc.).
- **No** adjustments to the billing system are allowed after receiving the audit notification letter.
- **Do not** submit Notification of Billing Error (NOBE) forms (for the review period) once you have received your notification letter. Any NOBEs submitted after audit notification will be included in the audit report process.
- Programs must send paper charts, if applicable, to Quality Improvement in a secure manner (i.e. via inter-departmental mail) to ensure they are received by 8:30 a.m. on the day of the audit.

Contract Programs:

To prepare for the Utilization Review Audit, program staff should ensure their medical records are in good order and all necessary documents are included in the chart.

- The program should review the chart list emailed five business days prior to the scheduled audit and run a service report to compare with the medical record(s) to verify that all billed services are represented with a corresponding progress note.
- Due to the pandemic, audits will not be conducted on site.
- All relevant chart documents will need to be submitted electronically through the SharePoint Service Upload portal (the same portal used for service upload files) to be available to the review team by 8:30am on the day of the audit.
  - For each client, please organize pdf files by chart section (ex: Legal/Financial documents, Assessment documents, CSP Documents, etc.).
  - If access to the portal is not available, documents may be faxed to 707-427-2774, or hand delivered to 275 Beck Ave. in Fairfield to be available to the review team by 8:30am on the day of the audit.
- Relevant documents include: Face Sheet, Payer Financial Information (PFI), Acknowledgement of Receipt, Consent to Treat (including Telehealth and Email/Text), Medication Consents, Release of Information (ROI), Assessments (including allergy info), Client Service Plans, Diagnosis form/report (if separate from Assessment), Progress Notes, Group Logs, and other applicable documents showing current medical necessity to cover review period.
  - For Ancillary programs, copies of the above documents from Primary programs should be included for the review.
- Prepare a signature list of all staff including their credentials.
- Please provide applicable group logs and NOBEs for the audit period.
- Only technical revisions may be made at this point (e.g. dates, filing, etc.).

- **No** adjustments to the billing system are allowed after receiving the audit notification letter.
- **Do not** submit Notification of Billing Error (NOBE) forms (for the review period) once you have received your notification letter. Any NOBEs submitted after audit notification will be included in the audit report process.

Step 4 – Day of the Review

On the day of the review, the review team will provide an additional chart list via email for a supplemental review. These charts must be submitted to the review team within two hours of the request. A review of the client waiting area/lobby and the medical room/area will be conducted to ensure compliance with Medi-Cal site certification criteria.

Other things to keep in mind:

- For documents that cannot be located in the charts submitted to the review team, the program will be contacted via phone to procure them within two hours of the request.
- For larger programs, the audit schedule may consist of multiple days, and programs will be notified when this is the case, if possible.

County Programs:
Programs must ensure all relevant chart documents are entered or scanned into the EHR no later than 8:30 a.m. on the day of the audit.

A Quality Improvement representative will email the supplemental chart list by 8:30 a.m. Charts must be ready for pick-up or scanned into the EHR within two hours of the sent email.

Contract Programs:
For the Primary Chart List, program staff should have all relevant chart documents submitted electronically through the SharePoint Service Upload portal to be available to the review team by 8:30am on the day of the audit. If access to the portal is not available, documents may be faxed to QI or hand delivered to the QI Unit. Refer to the audit worksheets for clarification of relevant documents.

The Supplemental Chart List a Quality Improvement representative will email the list by 8:30 a.m. Relevant chart documents must be submitted to the review team (via electronic portal or fax) within two hours of the sent email.

Step 5 – The Review

The following steps are taken by the review team:

- The clinical review is completed by a licensed member of the team. The technical review is completed by any member of the review team. See the Chart Review Worksheet for a comprehensive list of requirements for the primary charts.
    - The review team will use the Supplemental Audit Worksheet for the supplemental charts.
- A site evaluation will be completed by a member of the review team. See the Site Review Worksheet for a list of items/areas to be reviewed.
    - Medication room reviews may be scheduled on a different day.
- A reconciliation of all billed services is completed for each selected medical record. This is achieved by comparing all documented services in the medical record to the County's EHR client service listing report.
- Items identified as *out of compliance* will be noted on the final report and some may result in disallowance.
- Reasons for disallowed services include, but are not limited to the following:
    - Lack of established medical necessity on the Assessment/Re-Assessment and/or progress notes.
    - Missing or late Client Service Plans or a plan that does not include client/Authorized Representative's signature/reason for not obtaining client signature and stating how client participated in the creation of the plan.
    - Client Service Plan treatment objectives which do not address mental health symptoms or impairments.
    - Service Authorization: certain services that require prior authorization.
    - Progress notes that do not reflect the service plan treatment objectives.
    - Progress notes that lack adequate documented clinical interventions and client responses.
    - Use of incorrect procedure codes.
    - Missing and incomplete progress notes.
- Any documents that result in disallowed services will be copied or printed, then recorded on the service listing worksheet.

Step 6 – Verbal Audit Feedback (optional)

Upon completion of the medical records review, the reviewers may provide an informal oral report of the major findings to the program Supervisor, Clinical Head of Service and/or designated staff members via teleconference. This optional audit feedback includes a brief overview of the audit process, perceived areas of strength, and areas where training and attention would benefit the program. Scheduling of this feedback is to be arranged between the program representative(s) and the Quality Improvement Clinical Lead and take place no more than one week from the day of the review. Programs are encouraged to coordinate with the Quality Improvement Clinical Lead and/or e-mail qualityimprovement@solanocounty.com to request this meeting.

Step 7 – Audit Alert Period

Reviewers will complete an Audit Alert Form for each medical record that has items out of compliance that must be corrected immediately to avoid further disallowances. These forms will be submitted to the program following the audit and must be returned within

ten (10) business days of receipt with a copy of the corrected information requested. **An appeal of Audit Alert items is not necessary once corrected during this timeframe.**

During the Audit Alert time period, programs have the opportunity to submit a NOBE with supporting documentation to make a correction. If sufficient correction is submitted during the Audit Alert time period, these items will not be included in the audit report.

To complete Audit Alert corrections, the following applies:

- Correction(s) should not be re-entered into Avatar until your program has been instructed to do so by Quality Improvement.
- For programs with a hard copy medical record:
  - The original author of the progress note should review the corresponding progress note, strike one line through and initial any changes (exceptions are to be clarified with Quality Improvement).
  - Do not remove a disallowed progress note from the medical record if clinical content is valid.
- For programs with an EHR:
  - Please follow your program's procedures for amending/appending clinical documentation.
- **Failure to return Audit Alerts may result in disallowances.**

Step 8 – <u>Audit Report</u>

Quality Improvement Unit staff will compile a written report based on the tools completed during the utilization review, and any sufficient corrections reviewed from the program within the audit alert time period. For County programs this report will be emailed to the Program Supervisor and Program Manager. For Contracted programs this report will be emailed to the designated Clinical Head of Service and the County Contract Manager. Reports will be sent within 60-days following the completion of the audit alert time period.

The report will contain the following elements:

- A brief review of the audit details including the total dollar amount of services claimed for the review period, and the percentage of disallowed services of that total amount.
  - Services that were issued an Audit Alert and not corrected by program within the audit alert time period will be identified on the UR Disallowance listing.
- A comparison sheet from prior year reports identifying trends.
- A summary of findings across all medical records reviewed to assist in identifying areas of strength within the program, as well as areas where quality improvement is needed.
- A report of each medical record reviewed that identifies the findings, as outlined on the review worksheets.
- The findings of the site review.
- List of items requiring Corrective Action Plan.

Program Leadership are expected to share the results of the program utilization review audit with their staff as a continuous quality improvement activity.

All questions concerning the audit report(s) should be directed to the Mental Health Quality Improvement Audit Supervisor for clarification **prior** to submitting any appeals.

Step 9 – Corrective Action Plans

If the summary of the audit findings report identifies any review area that generates an audit finding of less than 80% compliance, a written Corrective Action Plan (CAP) will be required using the Solano County template.

The Correction Action Plan (CAP) is to be submitted by the program to the Quality Improvement Unit – Attn: Audit Supervisor within 60 days of the report being received. County will respond to CAP within 30 days of receipt. CAPs may be reviewed at the Solano MHP Compliance Committee meetings and system recommendations will be made based on overall trend analyses. Once the CAP is reviewed, programs will receive a written evaluation and may receive support from the clinical audit lead to assist with implementation and ensure adherence. Insufficient CAP must be resubmitted within 30 days of feedback. If second submission is still insufficient a report will be submitted to the Contract Manager and Mental Health Administrator.

CAP should include evidence of corrective action taken. Correction action must be completed and evidence submitted within six months of submitting the CAP to Quality Improvement. If a CAP is not submitted, a re-review of the program may be scheduled.

CAPs must be submitted within the above timeline regardless of intent to appeal (this is the same standard imposed by Department of Healthcare Services).

Step 10 – Appeals

Program Managers/Supervisors and/or Clinical Head of Services should review their report details very carefully.

The formal appeal process proceeds as follows:

- If programs wish to appeal the findings after receiving explanations for the recoupment detailed in the report, they may appeal in writing to the Quality Improvement Manager within fifteen (15) business days of receipt of the audit report.
  - Programs may request an extension by contacting the Quality Improvement Audit Supervisor within fifteen (15) business days of receipt of the audit report.
- The program Manager/Supervisor or Clinical Head of Service should address an official appeal letter to: *Quality Improvement Manager*.
- Appeal letters should contain an itemized list of disallowances to be considered for appeal **and** be accompanied by attached documents that are intended to support the appeal.

- If no appeal is submitted and received within fifteen (15) business days, or an extension requested, the audit report will stand as final.

CAPs must be submitted within the above timeline regardless of intent to appeal (this is the same standard imposed by Department of Healthcare Services).

Quality Improvement Manager will review and respond to appeals in writing via email within thirty (30) calendar days of receipt.

Step 11 - Program Responsibility after Final Audit Report* is Received

Within **20** business days of receipt of the final audit report, review the disallowance spreadsheet and sign the statement at the bottom to acknowledge the disallowed services and return to QI (this document may be included with the completed CAP). Signing the acknowledgement statement on the disallowance spreadsheet will also indicate your understanding of recoupment that will be deducted from a future vendor claim within the current fiscal year. Recoupment information will be coordinated between the contractor agency and county contract manager.

For disallowed services that require a correction to the client's medical record, please do the following:

- Submit a copy of each progress note for verification of correction.
- Correction(s) should not be re-entered into Avatar until your program has been instructed to do so by Quality Improvement.

*If no appeal is submitted by the program, the audit report will stand as final.