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Solano County Department of H&SS
Behavioral Health Division

Mental Health Bureau

UTILIZATION REVIEW

HANDBOOK

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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

Two weeks prior to the review, the Program Supervisor/Manager or 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

Two business days prior to the review, Quality Improvement will send a list consisting 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 faxed two business days prior to the scheduled audit.
- The program should ensure all paper documents that must be printed are filed in the hard copy chart (i.e., documents with wet signatures, already submitted for the audit period, etc.). If documents are located in the electronic medical record, they are not required to be in the hard copy chart.
- If paper documents exist in the chart, please flag all Assessments, Client Service Plans, Diagnosis forms or other documents showing current medical necessity as well as other applicable documents to cover the review period to ensure they are easily located.

- 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 placed on hold and may be considered part of the audit billing reconciliation (over and/or under-billed services) process.
- On the day of the audit, the program should provide a signature list of all staff and their credentials.
- Please provide applicable group logs and NOBEs for the audit period.
- Refer to fax coversheet (with the list of charts) for documentation to be flagged in the medical record.
- **Please note:** All documentation relevant to the audit period will be reviewed, including documents generated outside the review period which may have a significant impact on the review (e.g., client service plans, client assessment updates, assessments, etc.). If these documents are absent or not in compliance, the services may be disallowed for the audit period.
- Programs must send charts 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 faxed two 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.
- A hard copy version of the chart must be provided to auditors or provide logins to the agency's Electronic Health Record (EHR).
  - If providing access to an EHR:
    - Access to building at start time
    - Laptops or computers booted up prior to arrival
    - Brief orientation plus onsite technical support
    - Backup plan for login issues
    - Clear instruction on how to run reports and access documents
    - Ability for team to print independently
    - Table space to use PC/laptop & paper chart
    - Ventilated room due to heat generated from electronic equipment
- **Please flag** all Assessments, Client Service Plans, Diagnosis form and other applicable documents showing current medical necessity to cover review period to ensure they are easily located.
- 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 placed on hold and may be considered part of the audit billing reconciliation (over and/or under-billed services) process.
- On the day of the audit, the program should provide a signature list of all staff and their credentials.
- Please provide applicable group logs and NOBEs for the audit period.
- Refer to fax coversheet (with the list of charts) for documentation to be flagged in the medical record.
- **Please note:** All documentation relevant to the audit period will be reviewed, including documents generated outside the review period which may have a significant impact on the review (e.g. client service plans, client assessment updates, assessments, etc.). If these documents are absent or not in compliance, the services may be disallowed for the audit period.

Step 4 – <u>Day of the Review</u>

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

Other things to keep in mind:

- The reviewers require enough desk space to complete the audit without separating auditors into different rooms; the review team will likely consist of <u>four</u> to <u>eight</u> team members.
- The review team members would appreciate being provided, if at all possible, with comfortable chairs as they must sit for hours at a time during the review.
- Reviewers will need access to a copy machine.
- All medical records selected for the review must stay in the room for the duration of the audit, except in instances of unexpected emergencies.
- The utilization review should take place in a clean, well-lit area that allows for privacy and the ability to lock up the medical records during breaks to help ensure confidentiality.
- Arrangements should be made in advance to copy necessary documents from medical records of clients who may have doctor or clinician appointments scheduled during the audit.
- 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 send charts 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.

A Quality Improvement representative will fax or deliver the supplemental chart list by 9:00 a.m. Charts must be ready for pick-up within one hour of the fax stamp time.

Contract Programs:
For the Primary Chart List, program staff should have all relevant documents printed out* of the electronic record system and filed in the medical records identified on the chart list and available in a designated review area prior to the arrival of the Utilization Review team. Only provide previous volume if it contains progress notes within the audit period. Refer to the audit worksheets for clarification of relevant documents.
*Not required for records accessible from EHR.

For the Supplemental Chart List, charts must be provided to the review team within one hour of the request.

Step 5 – <u>The Review</u>

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.
- 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: programs not being authorized to provide services.
  - 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, under-billed, or over-billed services will be copied or printed, recorded on the service listing worksheet, and may be included in

the final audit report. Documents copied for additional review will be stamped "*Reviewed by Quality Improvement*"

Step 6 – Audit Feedback

Upon completion of the medical records review and if time permits, the reviewers will provide an informal oral report of the major findings to the program Supervisor, Clinical Head of Service and/or designated staff members. The audit feedback will provide a brief overview of the audit process, perceived areas of strength, and areas where training and attention would benefit the program. If it is too late in the day to provide this oral feedback, arrangements can be made to schedule a teleconference. Programs are encouraged to contact the Quality Improvement Audit Supervisor 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 – Audit Report

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. This report will be forwarded to the Program Supervisor (with a copy being sent to the Program Manager) for County programs or designated Clinical Head of Service (with a copy being sent to the County

Contract Manager) for contracted providers 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, and supporting documentation for each finding.
- 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 evaluated, programs 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).

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 complete a Notification of Billing Error (NOBE) form for each item disallowed. Please indicate on NOBE form it is for an 'Audit Correction.'

- Attach a copy of each progress note for verification of correction.
- If NOBE forms are not received, Quality Improvement will process the disallowed service(s).
- Correction(s) should not be re-entered into Avatar until your program has been instructed to do so by Quality Improvement.

For disallowed services that were not identified as re-billable during the Audit Alert time period, a NOBE is required with the appropriate documented corrections. For services that were eligible for correction during the Audit Alert time period but were not corrected within the timeframe a NOBE is required with the appropriate documented corrections.