# Internal Monitoring and Auditing to Identify Vulnerabilities and Problems in the Organization's Compliance Process

**Presented by:**

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# Final Webinar in a Series of Three on Compliance

- Important elements to remember:
  1. UM Plan development and implementation
  2. Organizational models that support "external" review model
  3. State and Federal Website Resources
  4. Medical Necessity qualitative support needed

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# Focus Areas for UM Plan

- **Front End** (i.e., Screening/Triage, Eligibility, Emergency Services, Referrals, etc.)
- **Concurrent** (i.e., Urgent/Routine Transfer/Discharge Criteria/Planning, Services for high risk consumers, qualitative review of clinical documentation and treatment planning, etc.)
- **Retrospective** (i.e., Qualitative/ Quantitative Review of Charts and Outcomes/Satisfaction Measures, etc.)

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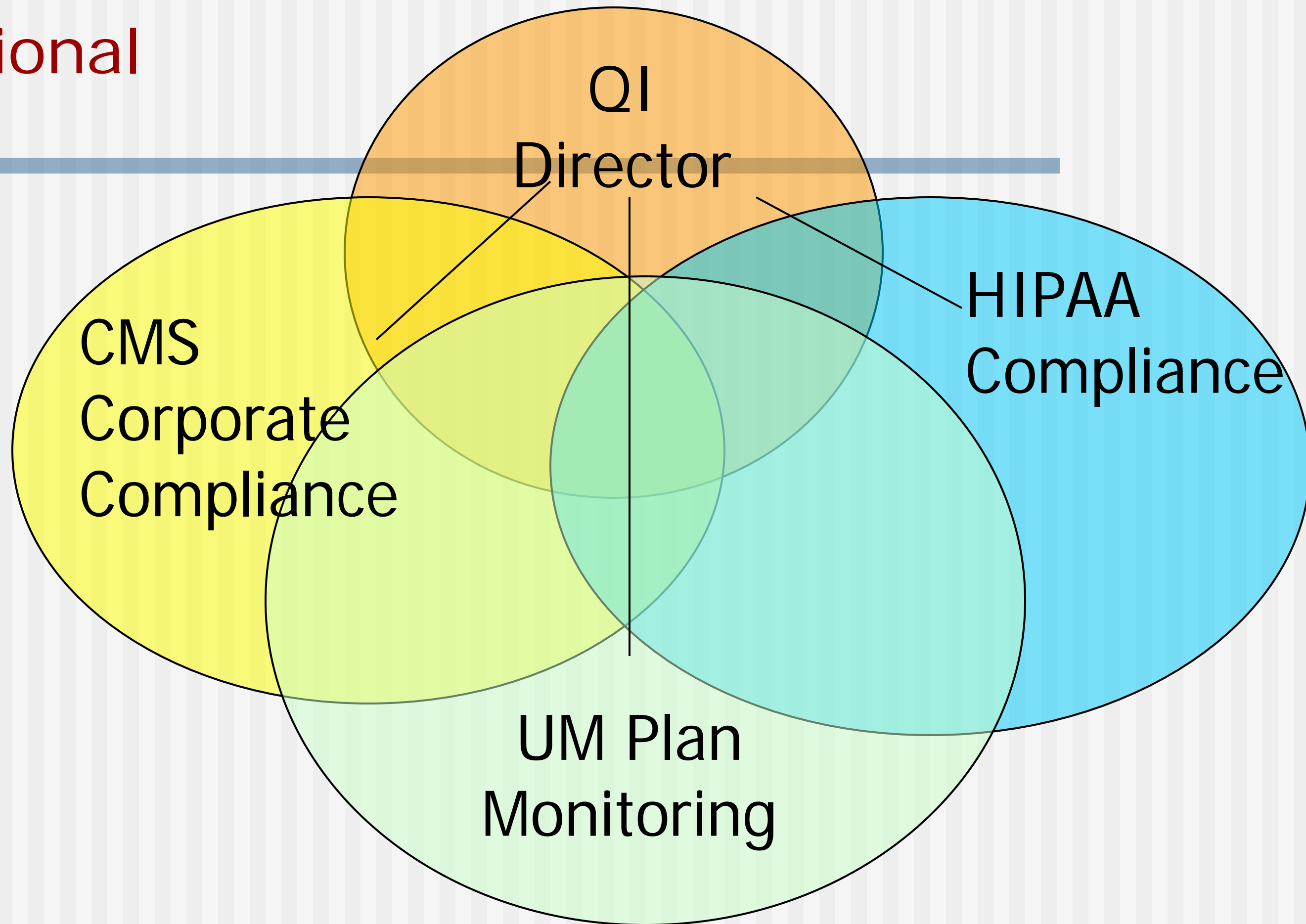
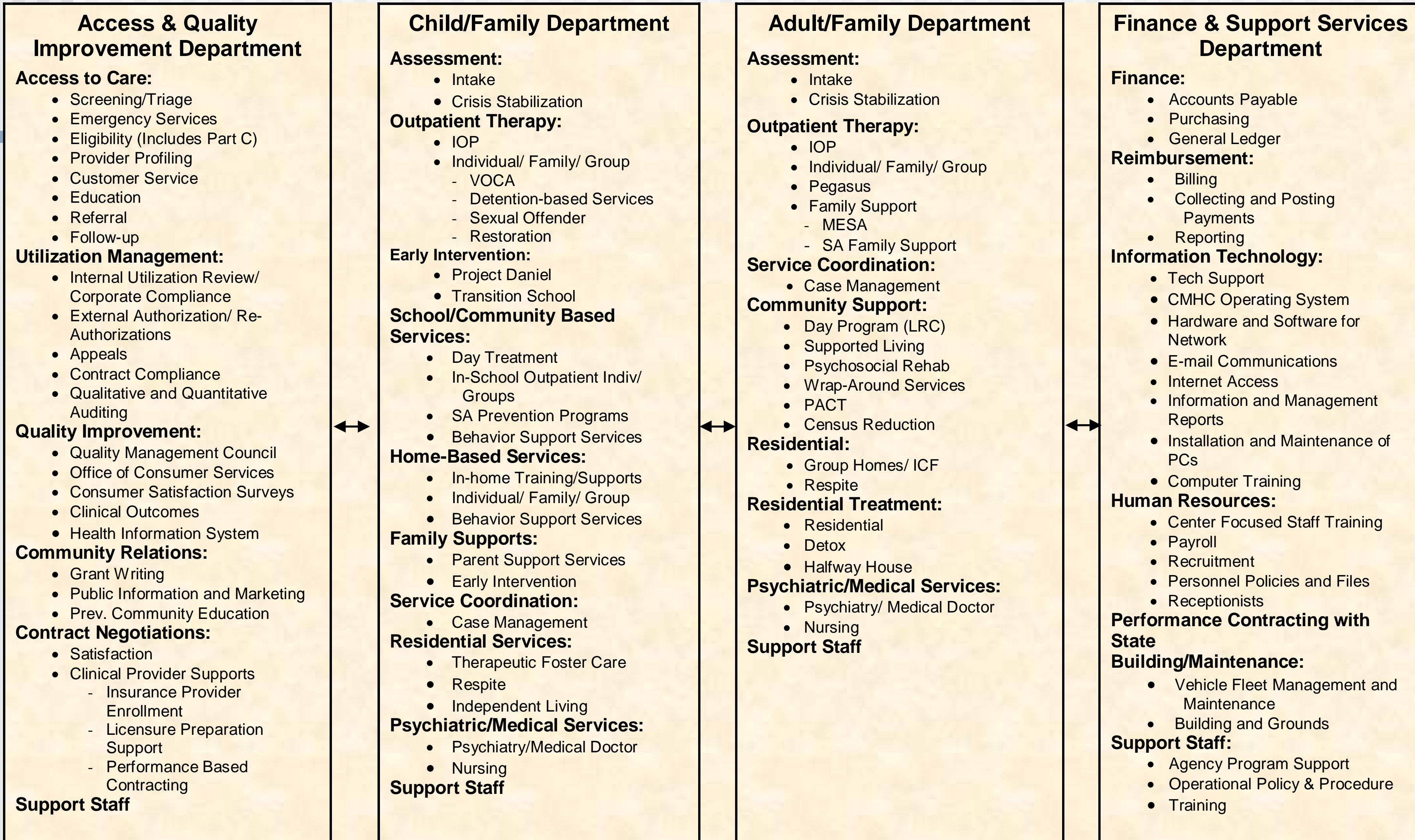
# Integrated Quality Improvement/ Organizational Structure

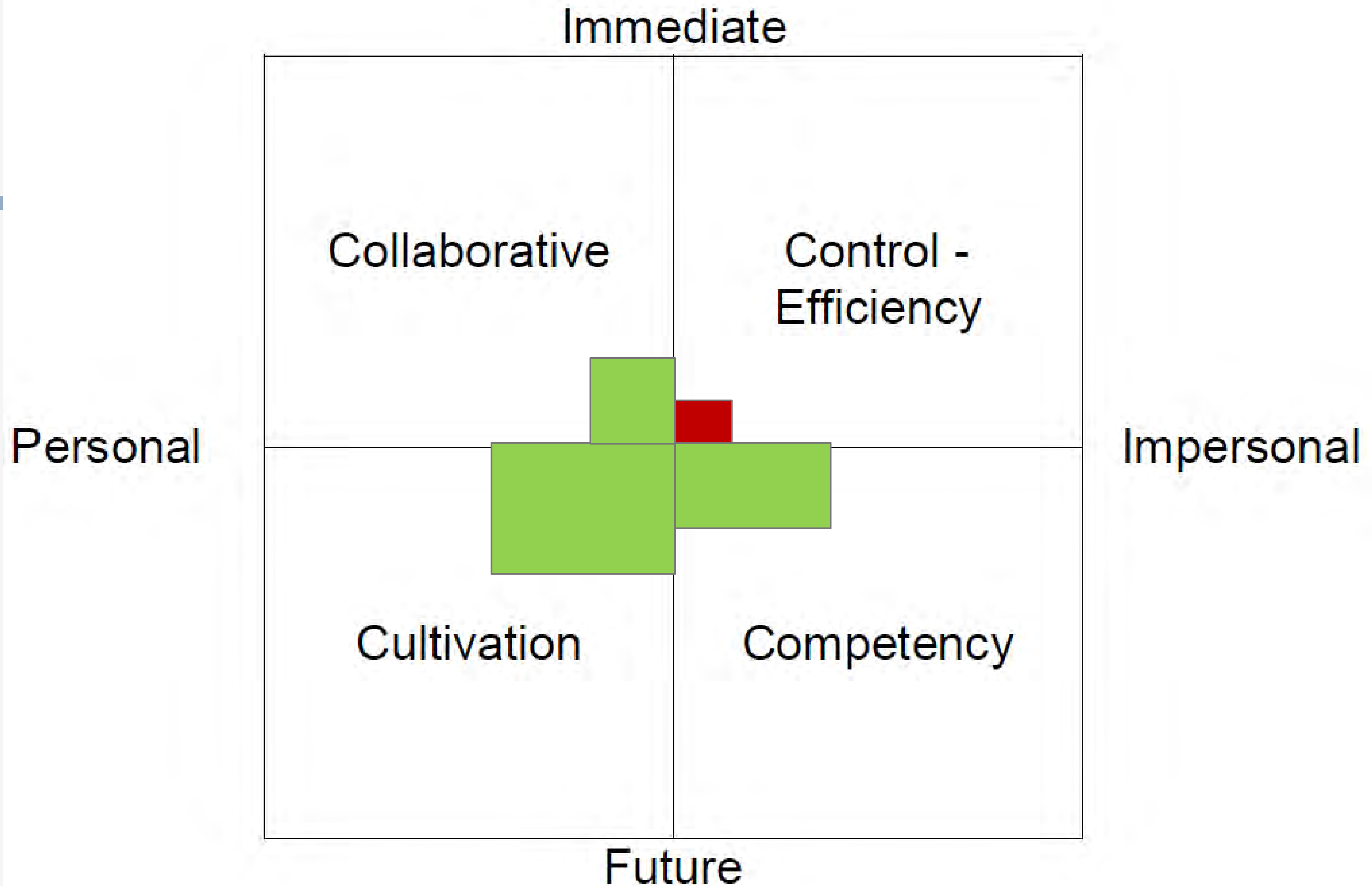



Clinical and Support/Admin staff assigned based on size of organization and active caseload

# Local Reviews to Support "Third Party Like" Approach



# Community Non-Profit Leadership Challenge – Team and Individual Levels



# OIG Audit Notification Letter for MHCs in Illinois in December 2005

At least one CMHP service, as provided by your facility during FFY 2003 (October 1, 2002, through September 30, 2003), was randomly selected for OIG review. The scope of our audit, as it applies to each selected service, will include, but is not limited to, a review of the following:

- Admission note,
- Mental health assessment or rehabilitation assessment, or related assessment documents,
- Individual treatment plan or rehabilitative services plan (we will generally require two individual plans: the plan authorizing the selected service and its immediate predecessor),
- Notes and other documentation directly relating to selected service,
- Provider certification applicable to the date of service and the location of service delivery, and
- Professional and educational credentials for staff involved with case documentation and the direct provision of selected services.

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# Five Documentation "**Golden Thread**" Linkage Processes in Forms

- **Five major linkage processes are built into the standardized form documentation system to support compliance with qualitative reviews.**

1. **Diagnostic Assessment – Identifies Treatment Recommendations/ Assessed Needs**
2. **Diagnostic Assessment Updates – Identifies New Treatment Recommendations/ Assessed Needs**
3. **Individualized Service Plan – Links goals to specifically numbered Treatment Recommendations/Assessed Needs**
4. **Individualized Service Plan Revisions - Links goals to specifically numbered Treatment Recommendations/Assessed Needs and/or changes in Objectives, Therapeutic Interventions, Frequency, Duration and/or Responsible Type of Provider.**
5. **Progress Notes – Links interventions being delivered to specific Goal(s)/Objective(s) and identified client response and outcomes/progress towards Goal(s)/Objective(s).**

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  - How to Receive DHS/DMH Services
  - Key DHS/DMH Services
  - Service Authorization
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## Medical Necessity

Medical necessity means providing services that fit your medical needs. Learning about it can help you work with your mental health center to make choices about your mental health care.

For rehabilitation services, like Community Support, Psychosocial Rehabilitation (PSR), or Assertive Community Treatment (ACT), medical necessity has a special meaning. These services must help you get back functions that have been interfered with by a mental illness or substance use disorder. At times a mental illness may make it hard for you to remember the steps to take care of yourself or to get a job. Rehabilitation services can help you learn and practice ways to overcome such negative effects of an illness.

These services may help you gain skills, use resources, or obtain and use supports. They can help you to modify your surroundings to make it easier to be successful in meeting your goals- as long as you need that help because of a mental illness or substance use disorder.

Medical necessity can help ensure that a service gives you or helps you find supports that you need. It can also help ensure that a service does not get in the way of your ability to live, work, learn and participate fully in a life in the community.

Illinois Department of Human Services
Michelle R.B. Saddler, Secretary

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# FY11 - Provider Manual

## FY11 Provider Manual Table of Contents


### I. INTRODUCTION

A. DHS/DMH Mission/Vision Statement

B. Philosophy of Recovery

C. Consumer and Family Handbook

D. Description of Role: Background, History, and Goals of the Illinois Mental Health Collaborative

### II. PROVIDER ELIGIBILITY

A. DMH Community Services Contract-Attachment B

B. Medicaid Enrollment

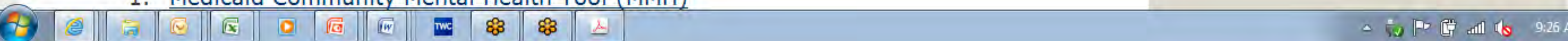
1. Provider Enrollment
2. Chapter CMH-100
3. Chapter CMH-200 Children's Mental Health (SASS) (pdf)
   a. Appendix (pdf)

C. Certification

1. Medicaid Community Mental Health Tool (MMH)


**Related Links**

- Continuity of Care, Strategic Planning Guidelines - Draft 10/15/10
- Medical Necessity Criteria and Guidance Manual



## V. PROVIDER MONITORING

A. Protocols (pdf)

B. Monitoring Tools

1. Post-Payment Review Tool (pdf)
2. Post-Payment Review Interpretive Guidelines (pdf)
3. Clinical Practice and Guidance Review Tool (pdf)
4. Clinical Practice and Guidance Review Anchors (pdf)
5. Clinical Practice and Guidance Review Interpretive Guidelines (pdf)
6. Plan of Improvement Template (doc)

C. Provider Complaints and Appeals

1. Medicaid-59 ILAC 132.44
2. Non-Medicaid Grants Recovery Process-59 ILAC 103.130

## VI. CLAIMS SUBMISSION FOR COMMUNITY SERVICES

A. Going Online: Tools and Resources

1. ProviderConnect
2. ProviderConnect Users Guide (pdf)
3. ProviderConnect Helpful Resources
4. Pseudo-RIN Information(FY11 content in development)
5. Place of Service Crosswalk (pdf)
6. Service Modifier (pdf)
7. Service Matrix(FY11 content in development)

B. Collaborative Software

1. Direct Data Entry (pdf)
2. EDI Claims
   a. Claim Line Separation Logic (xls)

Illinois Department of Human Services
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# Medical Necessity Criteria and Guidance Manual

Medical Necessity Criteria and Guidance Manual (pdf)

## Introduction

Consistent with Rule 132, DHS/DMH is providing enhanced Medical Necessity Guidance for the following Rule 132 services:

- Assertive Community Treatment (ACT) - adult only
- Community Support Team (CST) - adult and youth versions
- Psychosocial Rehabilitation (PSR) - adult only
- Community Support Group (CSG) - adult and youth versions
- Therapy Counseling (TC) - adult and youth versions
- Community Support Individual (CSI) - adult and youth versions

This guidance should be used by providers in making consistent treatment decisions with consumers. This guidance is to be used for each consumer, regardless of whether or not DHS/DMH or its designee externally authorizes the service. Provider adherence to this guidance may be subject to post payment review.

## THERAPY/COUNSELING - ADULT

### DIAGNOSIS:

1. The individual has a current eligible mental health diagnosis (as specified in 59 ILAC 132.25) for which the proposed course of treatment has been determined to be effective.

**Related Links**

- Continuity of Care, Strategic Planning Guidelines - Draft 10/15/10
- Medical Necessity Criteria and Guidance Manual

# Clinical Practice and Guidance Review Tool
# FY11

| Clinical Practice and Guidance<br>The purpose of this review is to assure adherence to clinical standards and assess quality indicators through the provider agency's clinical documentation and practices. This includes a determination of clear and consistent inter-connection among the diagnosis, assessed needs, ITP provisions, and actual services and interventions delivered. | | **Item Score**<br>**Record Review**<br>(Total of all scores for item/number of records reviewed) |
|---|---|---|
| 1 | Consumer name and/or identification number are on each page (created by the Provider) of the chart (right consumer, right chart). | |
| 2 | The current individual Treatment Plan is not a duplicate of prior treatment plans – updated per consumer progress and changing needs. | |
| 3 | The current Individual Treatment Plan is reflective of individually assessed needs. | |
| 4 | Diagnosis updating: V71.09, 300.9, and Rule Out diagnoses are not utilized or are updated and specified within six (6) months. | |
| 5 | Treatment is consumer driven as evidenced in clinical documentation. | |
| 6 | All recommendations for clinical interventions on the Mental Health Assessment and Individual Treatment Plan are being addressed in the actual service delivery. | |
| 7 | Level of billed service volume is consistent with the level of severity/need. | |
| 8 | There is evidence of changes in or re-evaluation of medication during periods of changing symptoms. | |
| 9 | There is documentation that the provider is assisting the consumer with moving him/her away from the provider as his/her primary support system and toward natural supports in the community. | |
| 10 | There is congruence between the information in the Mental Health Assessment and the Functional Assessment and/or LOCUS and/or Ohio Scales. | |
| 11 | There is evidence in the clinical record that primary health care coordination and integrated care is occurring with the primary physical health care provider | |
| 12 | Treatment provided builds on the identified strengths of the consumer. | |

Note: Individual chart review anchor scores are 1-3-5 or NA.

# POST-PAYMENT REVIEW SUMMARY

| **A. PROVIDER NAME:** | **B. REVIEW DATE:** Dates of on-site review |
|---|---|
| **C. PROVIDER #:** Collaborative provider/NPI | **D. Time Period Covered**: Date span for bills reviewed. These will be paid/adjudicated. The claim review period will begin 30 days following the FY10 PPR review date. |

| **CONTRACT AND RULE COMPLIANCE** | | |
|---|---|---|
| **Reason Codes:** | | |
| 1 | **The Mental Health Assessment report that relates to the claim is not signed and dated by the LPHA.**<br>Rule 132.148.a.7 | |
| 2 | **The Mental Health Assessment does not contain all elements as required by Rule 132, 2008 version.**<br>Rule 132.148.a.3.A-T (see attachment) | |
| 3 | **The Individual Treatment Plan (ITP) is not timely /not in effect at time of service.**<br>Rule 132.42a1 | |
| 4 | **Time billed is greater than time documented.**<br>Rule 132.100.i.3 | |
| 5 | **The volume of service activity documented in the note does not support the amount of time billed.**<br>Rule 132.100.i.3; 132.100.i.6 | |
| 6 | **No amount of time or actual time documented.**<br>Rule 132.100.i.3 | |
| 7 | **Documentation does not identify allowed mode of delivery.**<br>(Group, individual or family modality). Rule 132.100.i.1 | |
| 8 | **Documentation does not include the setting where services were rendered.**<br>Rule 132.100.i.5 | |
| 9 | **Location of service not correctly noted on-site vs. off-site**<br>Rule 132.100.i.5 | |
| 10 | **Documentation must include a description of the interaction that occurred during service delivery, including the consumer's response to clinical interventions and progress toward attainment of the goals in the ITP.**<br>Rule 132.100.i.6 | |
| 11 | **Service provided to ineligible person – service not available for persons in consumer's age category**.<br>i.e., Vocational 14 and older, PSR 18 and older<br>ACT - Rule 132.150.i.1, PSR - Rule 132.150.j.1 | |
| 12 | **Note describes a different service than billing submitted.**<br>Rule 132.100.i.1 | |
| 13 | **Note describes a service intervention or activity that is not billable.**<br>Rule 132.100.i.1 | |
| 14 | **Service provided by unqualified staff.**<br>Refer to attached grid for definitions of acceptable credentials. | |

# POST-PAYMENT REVIEW SUMMARY

| | | |
|---|---|---|
| | Rule 132.42.a.4; Rule 132.150 | |
| 15 | **Note not signed by staff providing service, including signature and credentials.**<br>Rule 132.100.i.4 | |
| 16 | **Specific service not authorized by ITP.**<br>Rule 132.42.a.3; Rule 132.148.c.2.C; 132.148.c.7 | |
| 17 | **The specific service is authorized by the ITP but is not based on a clinical need as identified in the mental health assessment or any additional evaluations.**<br>Rule 132.148.c | |
| 18 | **Service provided to ineligible person –Diagnosis in the clinical record is not a covered diagnosis.**<br>Rule 132.145.c; Rule 132.148 c.3 | |
| 19 | **No note to match date of service on billing submitted.**<br>Rule 132.100i | |
| 20 | **The Individual Treatment Plan in effect at the time of the claim could not be located in the clinical record.**<br>Rule 132.100c | |
| 21 | **The Mental Health Assessment in effect at the time of the claim could not be located in the clinical record.**<br>Rule 132.100d | |
| **COMMENTS:**<br>Reviewer comments of any other positives or concerns identified during the review. | | |
| | | |

# State of Illinois

# Department of Human Services/Division of Mental Health

# Medical Necessity Criteria and Guidance Manual

**Introduction**
Consistent with Rule 132, DHS/DMH is providing enhanced Medical Necessity Guidance for the following Rule 132 services:

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This guidance should be used by providers in making consistent treatment decisions with consumers. This guidance is to be used for each consumer, regardless of whether or not DHS/DMH or its designee externally authorizes the service. Provider adherence to this guidance may be subject to post payment review.

# Seven Elements of a Corporate Compliance Plan Overview

Presented By:
David Lloyd, Founder

# Compliance Plan Table of Contents

## Sample Table of Contents

1. Designating a Compliance Officer or Contacts
2. Conducting Internal Auditing and Monitoring
3. Responding Appropriately to Detected Offenses
4. Developing Open Lines of Communication
5. Enforcing Disciplinary Standards through Well-Publicized Guidelines

# CMS Compliance Requirements

- Clinical Quality
- Medical Necessity
- Documentation
- Client Rights
- Billing Accuracy
- Financial Requirements
- Fraud/Abuse

# Elements of a Corporate Compliance Plan

- US "Health and Human Services, law enforcement, and courts have given providers and individuals working in organizations a way to reduce their risk through the development and implementation of an "effective" corporation compliance program… as contained in the Federal Sentencing Guidelines describe seven elements that must be included in order for that program to be considered effective."

Source: "**Ahead of the Game**", by Mary Thornton, BSRN, MBA

# Elements of Corporate Compliance Plan

1. **Establishing rules and procedures** that are reasonably capable of reducing criminal conduct that must be followed by all employees and agents of the organization.
2. **Delegating of compliance oversight** to high-level personnel in the organization.
3. **Exercising due care** not to delegate managerial authority or oversight to individuals with a propensity to engage in criminal conduct. This includes individuals whom the entity knows or *should have known* have the propensity to engage in criminal conduct.
4. **Communicating compliance rules and procedures** to all employees and agents through training programs, distribution of educational materials, or other means.

Source: "**Ahead of the Game**", by Mary Thornton, BSRN, MBA

# Elements of Corporate Compliance Plan (Cont'd)

5. **Taking reasonable steps** to "police" employees and agents through random audits or by creating a reporting system that is confidential and protects the reporter from retaliation.
6. **Disciplining individuals** who both engage in misconduct, and who fail to detect misconduct.
7. **Taking the steps** necessary to reasonably respond to misconduct or offenses, and to prevent their recurrence.

Source: "**Ahead of the Game**", by Mary Thornton, BSRN, MBA

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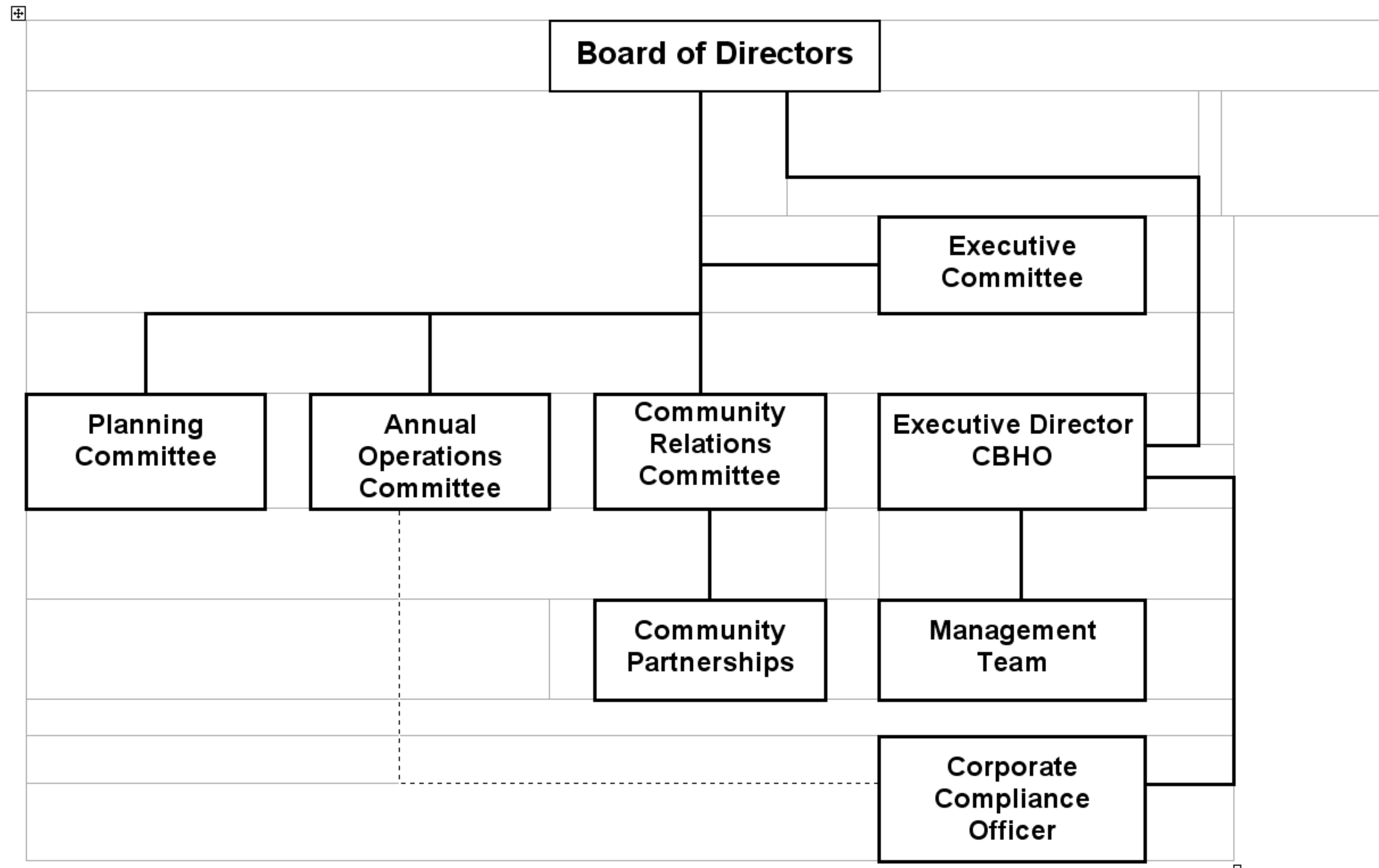
# Purpose of a Corporate Compliance Plan

1. The establishment of a written compliance plan, and the implementation of an effective program that is based on that plan have become critical to an organization's future financial health and position in the marketplace. Effective compliance programs will mitigate the organization's risk well before legal action becomes a concern.
2. An effective program should: **Prevent misconduct and violations** of law from happening in the first place.

Source: "**Ahead of the Game**", by Mary Thornton, BSRN, MBA

# Community Board of Trustees Policy Governance Recommended Stewardship Committee Structure Concept

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Presented By:
David Lloyd, Founder

# Corporate Compliance Performance Standards

| Title | CORPORATE COMPLIANCE PLAN |
|---|---|
| Standard | All employees are required to follow the policies and guidelines outlined in the Agency's Corporate Compliance Plan. These guidelines and policies include ethical practices, employee conduct, integrity of financial reporting and compliance with local, state and federal laws and licensing entities. |
| Source | Results of investigations conducted by Compliance Coordinator and/or audits conducted by Risk Management Department. |
| Compliance Rating | 100% = Compliance on Type One Occurrences<br>2 or less citations = Compliance for Type Two Occurrences<br>3 or more citations = Non-Compliance on Type Two Occurrences |
| Solution Plan | Meet with HR Administrator and Division Director within 48 hours of non-compliance to review plan of correction. Non-compliance may result in disciplinary action up to and including termination of employment, depending on severity of incident. |

# HIPAA Compliance Performance Standards

| Title | **HIPPA COMPLIANCE** |
|---|---|
| Standard | Employees will comply with Agency HIPPA policy concerning client and employee Personal Health Information. |
| Source | HIPPA Compliance Officer and HR Administrator |
| Compliance Rating | 100% = Compliance on Type One Occurrences<br>2 or less citations = Compliance for Type Two Occurrences<br>3 or more citations = Non-Compliance on Type Two Occurrences |
| Solution Plan | Inadvertent violations of HIPPA policy will result in a Corrective Action Plan being developed by the HIPPA Compliance Officer, Human Resources Administrator, and Division Director. Intentional violations or a pattern of non-compliance with HIPPA policy will result in disciplinary action up to and including termination of employment. |

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# Sample Clinical Compliance Performance Standards

**Credentialing Standards:**

**1. Training/Continuing Education**

**Definition-** Time attended at conference, seminar, training, or course that is related to profession and enhances knowledge and or skills. May include approved independent review of professional literature.

**Standard-** During the last 3-month period provider accumulated 7 hours of continuing education training.

**Source-** Human Resources

**Compliance Rating-** 7 hours = Full compliance;
Below 6 hours = Non-compliance

**Solution Plan-** Employee must accumulate needed hours within next Quarter.

**2. Licensure/Registration**

**Definition-** Provider has maintained license or registration appropriate to profession and appropriate to job requirement.

**Standard-** License or registration has been maintained at all times of employment.

**Source-** Human Resources

**Compliance Rating-** License/registration maintained = Full compliance
License/registration lapsed = Non-compliance

**Solution Plan-** Provider applies for license/registration within 72 hours of report.

# Sample Clinical Compliance Performance Standards

**3. Ethical Standards of Profession**

**Definition-** Provider has not been cited by other providers or by consumers for unethical practice and meets standard for own profession.

**Standard-** Provider has not received a citation of unethical behavior or practice.

**Source-** Human Resources/Compliance Officer

**Compliance Rating-** No citations = Full compliance
1 or more citations = Non-compliance

**Solution Plan-** To be determined by administration at time of citation.

**4. Participation in Supervision**

**Definition-** Time provider spends participating in group or individual supervision with his/her supervisor or psychiatrist. For provider's whose license requires specific supervision, provider has met requirements for supervision based on licensure definitions.

**Standard-** Provider has participated in 6 hours of supervision in last 3 months and has met the requirements of supervision required by his/her license/registration.

**Source-** Human Resources

**Compliance Rating-** 6 hours & meets license/registration requirements = Full Compliance
Less than 4 hours = Non-compliance

**Solution Plan-** Provider will meet with supervisor within 7 days of report to develop plan to increase compliance.

# Sample Clinical Compliance Performance Standards

**5. Services in compliance with license**

**Definition-** Services the provider is providing is within the limits of services that can be provided as defined by the type of licensure the provider has.

**Standard-** Provider only provides services that his/her license permits.

**Source-** Staff Activity Logs from MIS

**Compliance Rating-** All services provided are within limits of license = Full Compliance
Services provided not within limits of license = Non-Compliance

**Solution Plan-** Provider will not provide services outside of limits of license.

**Services:**

**Available hours**

**Definition-** The number of hours during the workweek the provider is available for scheduled appointments. This is the standard for Outpatient services provided. Definition and standard for other services will be developed as a better understanding of how to pro-rate other services outside of the office.

**Standard-** During the 3-month period, the provider is available for 400 hours of scheduled appointments.

**Source-** Staff Activity Log and MIS

**Compliance Rating-** Provider is available 375-400 hours = Full Compliance
Provider is available less than 375 hours = Non-Compliance

**Solution Plan-** Provider will meet met standard within next quarter.

# Sample Clinical Compliance Performance Standards

**Case Documentation Compliance**

**Meets Utilization Management**

**Definition-** Provider has completed documentation for request for services, including type of service requested and frequency and duration of services and the services are medically necessary.

**Standard-** Provider will only provided services that have been authorized by Utilization Management and will provide services within the authorized frequency and duration of services. Provider will request for additional services when initial authorization has been met.

**Source-** Utilization Management

**Compliance Rating-** Provider had authorization for 95-100% of services = Full Compliance
Provider had authorization for less than 94% of services = Non-Compliance

**Solution Plan-** Provider will meet with supervisor within 7 days of report to develop plan to increase compliance with authorization.

**Assessment completed.**

**Definition-** Written assessment of individual's history, mental status, strengths, needs and resources including recommendations for treatment is completed.

**Standard-** Individual Assessment is completed within 5 days of assessment appointment and treatment team, consumer's and parent/guardian (if applicable) signatures are obtained within 10 days of report completion.

**Source-** Peer Review Ratings

**Compliance Rating-** Provider completed 95% of IPS within standards = Full Compliance
Provider completed less than 94% within standards = Non-Compliance

**Solution Plan-** Provider will meet with supervisor within 7 days of report to develop plan to increase compliance.

# Sample Clinical Compliance Performance Standards

6. Intake/Assessment completed.

**Definition**- Written assessment of individual's history, mental status, strengths, needs, abilities, preferences and resources including recommendations for treatment.

**Standard**- Individual Assessment is completed within 5 working days of intake/assessment appointment and treatment team, and consumer's and parent/guardian signatures are obtained within 10 working days of report completion.

**Source**- Completeness review of charts

**Compliance Rating**- Clinician completed 95% of assessments within standards = Full Compliance
Provider completed 94% or less within standards = Non-Compliance

**Solution Plan**- Provider will meet with supervisor within 7 working days of report to develop plan to increase compliance.

7. Individual Treatment Plan (ITP) completed.

**Definition**- Individual Treatment Plans are to be completed with statement of problem(s), identified goal(s) and objective(s) to address the identified problem(s) and interventions/services to be provided to attain goals with frequency and provider of services.

**Standard**- ITPs are to be completed during the 2nd face to face appointment and every 90 days thereafter with consumer after the completion of the assessment and consumer's and parent/guardian (if applicable) signatures are to be obtained at ITP completion.

**Source**- Completeness review of charts

**Compliance Rating**- Provider completed 95% of ITP within standards = Full Compliance
Provider completed 94% or less within standards = Non-Compliance

**Solution Plan**- Provider will meet with supervisor within 7 working days of report to develop plan to meet the standard.

# Sample Clinical Compliance Performance Standards

8. Documentation supports diagnosis and services

Definition- Assessment and other documentation provide sufficient reasoning for diagnosis and the type, frequency and duration of services provided.

Standard- ITP and other documentation clearly identify symptoms and severity and clearly identify services that specifically address those symptoms.

Source- Utilization/Peer (QA) Review

Compliance Rating- 95% documentation supports = Full Compliance
Less than 94% of documentation supports = Non-Compliance

Solution Plan- Provider will meet with supervisor within 7 working days of report to develop plan to increase compliance.

9. Progress notes completed

Definition- Progress notes are completely filled out. They refer to treatment plan goals and objectives and address consumer's progress. They are signed and dated by provider.

Standard- Progress note will be completed by noon the day following services and signed within 48 hours.

Source- Completeness Review

Compliance Rating- 95% of Progress notes completed within standards = Full Compliance
94% or less of progress notes completed within standard = Non-Compliance

Solution Plan- Provider will meet with supervisor within 7 working days of report to develop plan to increase compliance.

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# Sample Clinical Compliance Performance Standards

**10. Discharge summary completed**

<u>Definition</u>- Discharge summary is completed with provider signature and consumer notification documented according to discharge protocol.

<u>Standard</u>- Discharge summaries will be completed within 3 working days of consumer's case being closed or no later than 90 days after the last service. Signatures will be obtained within 10 working days of summary's completion. Consumer will be notified prior to discharge summary and this notification will be documented on discharge.

<u>Source</u>- Completeness Review

<u>Compliance Rating</u>- 95% of discharges completed within standards = Full Compliance
94% or less of discharges completed within standards = Non-Compliance

<u>Solution Plan</u>- Provider will meet with supervisor within 7 working days of report to develop plan to increase compliance.

**11. Daily Log Sheet completed timely**

<u>Definition</u>- Daily Log Sheet is the data collecting system that provider's will complete to reflect all billable hours. Each billable activity a Provider has will be entered against the appropriate consumer with the appropriate activity code and duration being accurately entered into the system.

<u>Standard</u>- DLS's will be completed and turned in by noon the day following services

<u>Source</u>- MIS

<u>Compliance Rating</u>- 95% of DLS's completed within standard = Full Compliance
94% or less of DLS's completed within standard = Non-compliance

<u>Solution Plan</u>- Provider will meet with supervisor within 7 days of report to develop plan to increase compliance.

## Provider's Performance Evaluation

**Date:**
**Provider Name:** **Position Title:**
**Type of Evaluation: ❑ Initial, ❑ Quarterly, ❑ Annual, ❑ Other: ____________**
**Compliance Ratings:**
1=Full Compliance
0=Non-Compliance

| Individual Provider: | Compliance Rating | Comments |
|---|---|---|
| **Credentialing Standards:** | | |
| Participation in supervision | | |
| **Services:** | | |
| *Billable hours | | |
| Client initial no show rate | | |
| Client ongoing no show rate | | |
| Provider kept appointment rate | | |
| **Case Documentation Compliance:** | | |
| *Intake/Assessment Completed | ❑ N/A | |
| *ITPs Completed | ❑ N/A | |
| Documentation supports diagnosis, Goals in ITP and services | | |
| *Progress notes completed | | |
| Discharge Summary completed | ❑ N/A | |
| **Data Collection:** | | |
| *DLSs completed timely | | |
| *DLSs completed accurately | | |

* NOTE: Indicates Core Performance Indicators

# Sample Non-Clinical Compliance Performance Standards

1. **Medicaid Billings:**
   - Definition: MIS will submit appropriate billings to MACSIS timely and accurately
   - Standard: Billing of Medicaid and non Medicaid completed and submitted every other Thursday
   - Source: Verification Report of billings submitted and rejects report
   - Compliance Rating: Bi-weekly billings 100% of the time with less than 3% rejects
   - Solution Plan: MIS will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within next report period.
2. **MACSIS Enrollments:**
   - Definition: MIS will ensure UCI numbers are received and entered on all clients eligible for public funding.
   - Standard: Medicaid enrollments will be submitted daily to funding boards on previous days eligibles and UCI's entered upon receipt.
   - Source: Report every other Thursday to determine UCI numbers missing
   - Compliance Rating: 95% of the time
   - Solution Plan: MIS will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within next report period.

# Sample Non-Clinical Compliance Performance Standards

1. **Logs Entered into MIS:**
   - Definition: MIS will ensure timely and accurate entering of logs to billings can be achieved in a timely manner
   - Standard: All previous days logs will be entered accurately by 5:00 p.m. each day.
   - Source: A report will be made by 9:00 a.m. each day of outstanding logs
   - Compliance Rating: Compliance: 90% of the time
     Non Compliance: 89% or less of the time
   - Solution Plan: MIS will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within next report period.
2. **Collection of co-pays and Medicaid cards:**
   - Definition: Front desk will check daily client information to determine medical card or co-pay status for appropriate collections.
   - Standard: Front desk will collect co-pays and copies of Medicaid cards at the time of client visit.
   - Source: A monthly report at month end by MIS will reflect outstanding co-pays or medical cards not received during the month.
   - Compliance Rating: 95%
   - Solution Plan: Staff will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within the next report period.

# Sample Non-Clinical Compliance Performance Standards

1. **Insurance denial rate:**
   - Definition: Insurance information will be checked with the client at each visit and appropriate providers will be assigned to clients based on insurance qualifications.
   - Standard: Insurance claims will be submitted accurately.
   - Source: A monthly report at month end by MIS will reflect outstanding insurance over 90 days received
   - Compliance Rating: Denial rates will be less than 10% of total insurance billings monthly.
   - Solution Plan: Staff will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within the next report period.
2. **Telephone support**
   - Definition: Daily coverage of phones by telephone support specialist and back up personnel Standard: Telephone station to be manned during peak hours of 7:30-5:00 daily
   - Source: Weekly schedule
   - Compliance Rating: 90%
   - Solution Plan: Staff will meet with supervisor to determine -factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within the next report period.

# Sample Non-Clinical Compliance Performance Standards

1. **Submission of $2^{nd}$ and $3^{rd}$ Party Billings**
   - Definition: Financial operations team member submits $2^{nd}$ and $3^{rd}$ party billings accurately
   - Standard: $2^{nd}$ and $3^{rd}$ party billings submitted accurately by the $5^{th}$ working day of the month
   - Source: Monthly figures balanced and given to Associate Director of Operations who signs and dates receipt
   - Compliance Rating: 95% of the time
   - Solution Plan: $2^{nd}$ and $3^{rd}$ party billing operations team member will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within the next report period.
2. **New Charts Completed:**
   - Definition: Financial data, state sheets, activation of chart and-5ompletion of chart will be done on a daily basis.
   - Standard: New charts will be completed in total within I working day of intake.
   - Source: A list of intakes each day will be provided and dated when chart is completed and submitted to record department for filing.
   - Compliance Rating: Charts will be completed 95% of the time.
   - Solution Plan: Re-verification Operations team member will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within the next report period.

# Sample Non-Clinical Compliance Performance Standards

1. **Obtaining Preauthorization of Insurance**
   - Definition: Staff will ensure that authorization is obtained 2 days prior to client's schedule appointment
   - Standard: All insurance clients will be pre-authorized prior to scheduled appointments.
   - Source: Copy of authorization kept in log book.
   - Compliance rating: 95% of the time
   - Solution Plan: Staff will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within the next report period.
2. **Payables:**
   - Definition: Bookkeeper will enter all payables within 3 days of receipt and process payments timely.
   - Standard: Payments on payables will be made within 30 days of entry/invoice date.
   - Source: Weekly invoice list
   - Compliance Rating: 85% of the time
   - Solution Plan: Bookkeeper will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within next report period.

# Sample Non-Clinical Compliance Performance Standards

1. **Income Verification completed:**
   - Definition: Re-verification operations team member will obtain and complete income verification timely and accurately.
   - Standard: Income verification will be completed every 6 months on all clients
   - Source: Monthly report ran to determine verifications not completed
   - Compliance Rating: 95% of the time
   - Solution Plan: Re-verification operations team member will meet with super-visor to determine factors that interfered with compliance within 7 work days and a plan will be developed to meet compliance within the next report period.
2. **Verification of next days scheduled intakes by telephone call:**
   - Definition**:** Intake operations team member will obtain verification of the next days scheduled intake.
   - Standard: Intake operations member will make at least 2 attempts to verify that client will be attending the next days scheduled intake appointment.
   - Source: Intake operations member tracks intakes and initials next days schedule that telephone call(s) for verification has been made.
   - Compliance Rating: 90% of the time
   - Solution Plan: Intake operations team member will meet with supervisor to determine factors that interfered with compliance within 7 days and a plan will be developed to meet compliance within the next report period.

# Non Clinical Performance Evaluation

**Date:**
**Provider Name:** **Position Title:**
**Type of Evaluation: ❑ Initial, ❑ Quarterly, ❑ Annual, ❑ Other: ____________**
**Compliance Ratings:**
**1=Full Compliance**
**0=Non-Compliance**

| Individual Provider: | Compliance Rating | Comments |
|---|---|---|
| Income Verification Completed: | | |
| Payer Verification: | | |
| Transcription Timeliness: | | |
| Documentation Filing Timeliness: | | |
| Logs Entered: | | |
| Collection of Co-Pays and 1st Party Payments: | | |

# UM Plan Summary

- **Chart Review Sampling Requirements/Procedures Authorized:**
- **Level I Review:** 100% reviews shall be conducted on all admission, continuing stay, and discharges, as outlined in Administrative Policies
- **Level II Review:**
- **Substance Abuse Services:**
  1. A service data report is generated to identify all admissions, continuing stay, and discharges within each quarter.
  2. The UM Chairperson receives the list and calculates the number of files to be reviewed as determined by funding and/or licensure requirements.
  3. A minimum sample of 15% of these records must be selected for review. DUI samples shall consist of at least 15%, but no less than five and no more than 20 cases. The cases for review will be selected on a random basis.
  4. The reviews are conducted and feedback provided as outlined in Administrative Policies
- **Mental Health:**
  1. A service data report is generated to identify all admissions, continuing stay, and discharges within each quarter.
  2. The Support Team Manager receives the list and calculates the number of files to be reviewed as determined by funding and/or licensure requirements.
  3. A minimum sample of 10% of all Medicaid files will be reviewed quarterly. The cases for review will be selected on a random basis.
  4. The reviews are conducted and feedback provided as outlined in Administrative Policies

Service Delivery

LPHA authorizes initial services

UM

Change services/ level of care

Utilization monitoring for service pattern variance (outliers)

UM Decides on Services

Physician Review

UR for clinical appropriateness/ change in level of care

Service Approved

Level 2 Review Requested by Clinician & Manager

Service Not Approved

NO

Level 1 Review initated by UM. Are services appropriate?

Service Approved

Appeal for Peer Review by Manager or Client

Service Not Approved

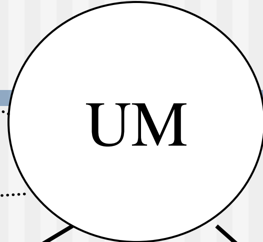
Yes

Continue services/ level of care

# SERVICE DELIVERY

CONTINUED FROM REFERRAL PROCESS

UTILIZATION MONITORING PROCESS




CONSUMER NEARS SERVICE LIMIT

INTERNAL UM FOR CHANGE IN LEVELS AND CLINICAL APPROPRIATENESS

CLINICIANS

HAS DISCHARGE CRITERIA BEEN MET?

NO

YES

CLOSE FROM PROGRAM/ REFER

GET EXTERNAL AUTH

YES

NO

CLINICAL APPEAL?

YES

NO

GET EXTERNAL AUTH

REFER TO DIFFERENT LEVEL OF CARE ?

YES

NO

DISCHARGE/REFER OUT

“Advocacy” Model

# Outlier Management Model Vs. 10% Random Selection Chart Review

- 10% Random Sampling Model is at best an attempt to review the outliers, but not a guarantee
- Even if 10% sampling is doubled to 20% based on more than 5% adverse findings, at best again there is an attempt
- Outlier Management reviews 100% of the service utilization and qualitative correlation factors to identify the specific charts that should be pulled for UM review

# SPQM Outlier Management Protocols

1. Fidelity to Best Practices Protocols
2. Client Specific Service Utilization Protocols
3. Staff Utilization Protocols
4. System-wide Utilization Protocols

SPQM Reports

# Focus on Utilization Measures

1. **Best Practices/Protocols**:
   a. **Axis I Diagnostic Chart/Axis II Diagnostic Chart**: Review for total client service hours by diagnosis across programs. Identifies the relative amount of service for each diagnostic group.
   b. **Diagnostic Resource Distribution Chart**: Review to develop and monitor clinical protocols and practice guidelines and resource utilization by diagnostic profile.
   c. **Functional Score/GAF Chart**: Use either the individual GAF indicators or the GAF Groups to determine if appropriate intensity of service and service array is being provided to lower, moderate and higher functioning clients. (i.e., appropriate GAF levels for Assertive Community Treatment would be 21 to 40 based on audit outcomes).

SPQM Reports

# Focus on Utilization Measures

2. **Client Service Utilization**:
   a. **Hi Utilizer Chart**: Information is shown by case number. Identifies the type of service and the amount of time for each service. Compare relative values/total amount of services for the top and bottom clients during the reporting period to determine if there are outliers. Use Diag1 Group and Diag2 Group indicators and bring in GAF scores along the bottom to help determine any qualitative reasons for practice variance by client.
   b. **Client Service Gestalt**: Indicates trend report of all services and amounts of service delivered to a single client of the report period. Look for trends of increasing or decreasing services, crisis services, etc.

# SPQM Reports

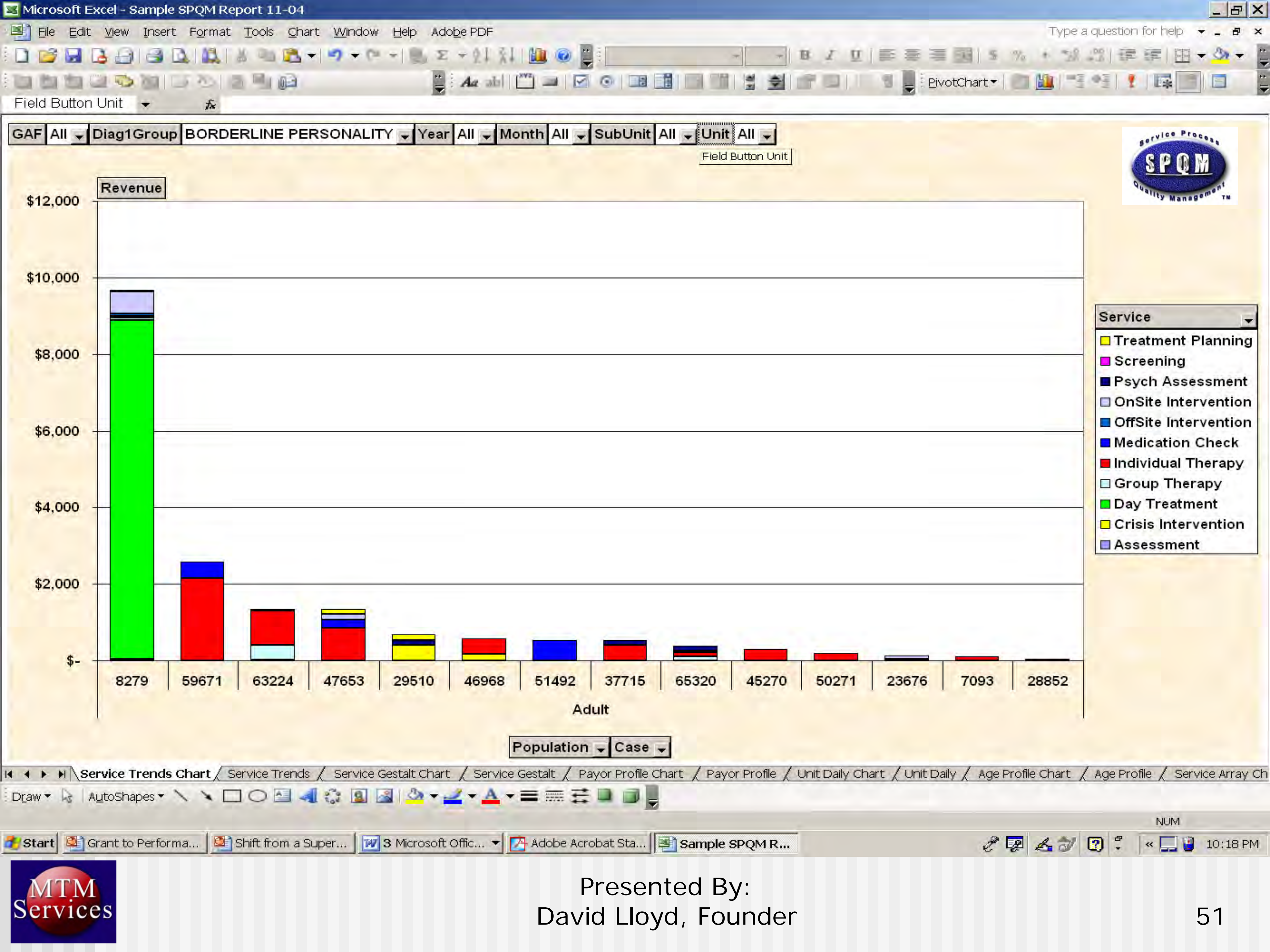
# Focus on Utilization Measures

3. **Staff Practice Patterns**:
   a. **Hi Utilizer Chart**: Confirm which staff have the most high utilizer clients in their case load.
   b. **Practice Variance Chart**: Confirm the average service delivery times for individual staff for specific services. Confirm if reason for difference is due to GAF and/or Diagnostic profiles of clients. If not, confirm with clinical management differences identified.
   c. **Services by Staff Report**: Identify service type by provider and confirm outlier minimum, maximum and average times and report identified outliers. Please confirm with finance staff any maximum times that should not have been billed.
   d. **Staff Services Report**: Use to identify provider outliers as indicated in 3c above.

SPQM Reports

# Focus on Utilization Measures

4. **Systems Utilization Patterns**:
    a. **Monthly Service Volumes Chart**: Levels of service provision in different programs/RUs. Useful to identify specialty programs such as ACT and SASS, etc.
    b. **Hi Utilizer Chart**: Check which programs have the most high utilizers and outliers based on diagnostic profile and GAF levels.
    c. **Unit Production Chart**: Trend in overall performance levels of direct services provided over timeframe of the report.
    d. **Organizational Units Report**: Indicates average client time and maximum client time which indicates unusual resource utilization by unit/program.
    e. **Services Report**: Average and maximum client times indicate which services are over and under utilized by unit/program.
    f. **Service Averages Chart**: Provides the average time required to deliver each service in the MHC. Look for outliers based on funders' requirements.
    g. **Axis I and Axis II Charts**: Provides a summary of the diagnostic groups in terms of the level of direct services provided and the organizational unit providing the services.
    h. **Practice Variance Chart**: Indicates average time it has taken per staff and per service to deliver the service during the reporting period. Use to monitor major variances by staff per service code and use to implement best practice standards for the appropriate time required.
    i. **Services Report**: Identifies Average and Maximum client time which services are under or over utilized by unit/program.


Microsoft Excel - Sample SPQM Report 11-04
GAF All Diag1Group BORDERLINE PERSONALITY Year All Month All SubUnit All Unit All
Field Button Unit
Revenue
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
8279
59671
63224
47653
29510
46968
51492
37715
65320
45270
50271
23676
7093
28852
Adult
Population Case
Service
Treatment Planning
Screening
Psych Assessment
OnSite Intervention
OffSite Intervention
Medication Check
Individual Therapy
Group Therapy
Day Treatment
Crisis Intervention
Assessment
Service Trends Chart / Service Trends / Service Gestalt Chart / Service Gestalt / Payor Profile Chart / Payor Profile / Unit Daily Chart / Unit Daily / Age Profile Chart / Age Profile / Service Array Ch
MTM Services

# Diagnostic Group – Major Depression

Top 70 Utilizers by Client Time

Clime Hours

350
300
250
200
150
100
50
0

Screening
Crisis Intervention
Missed Appt
Family Therapy
Collateral Intervention
CaseMgt-Office
Psych Assessment
CaseMgt-Offsite
Psychological Testing
Treatment Planning
Individual Therapy
Day Treatment
Hospital Screening
Medication Check
Crisis Assessment
Assessment
Group Therapy

Microsoft Excel - Sample Behavioral Health Organization SPQM Data July 2002

File Edit View Insert Format Tools Chart Window Help Adobe PDF

Field Button Month

| SubUnit | (All) | Unit | (All) | StaffName | (All) | Div | (All) | Population | (All) | Diag1Group | SCHIZOPHRENIA | Month | (All) | Diag2Group | (All) | Service | (All) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Total**

Ctime

216:00
192:00
168:00
144:00
120:00
96:00
72:00
48:00
24:00
0:00

| 70 | 65 | 65 | 55 | 50 | 50 | 50 | 55 | 60 | 50 | 50 | 55 | 55 | 58 | 50 | 55 | 55 | 50 | 60 | 55 | 50 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 54225 | 43169 | 59155 | 55521 | 32537 | 47421 | 45474 | 36607 | 28118 | 45945 | 45090 | 41734 | 46483 | | 48252 | 45681 | 35240 | 7379 | 35147 | 33622 | 43485 |

Drop Series Fields Here

Total

Case GAF

Appointment Code Patterns Chart / Appointment Code Patterns / Appointment Code Profile Chart / Appointment Code Profile / Day in the Life / Hi Utilizer Chart / Hi Utilizers / Staff Resource P

Draw AutoShapes

NUM

Start | America Online 9... | SPQMCal's Calen... | 3 Microsoft Off... | Microsoft Power... | Adobe Acrobat S... | Book1 | Sample Behavi... | 7:49 AM

Presented By:
David Lloyd, Founder

SubUnit (All) | Unit (All) | StaffName (All) | Div (All) | Population (All) | Diag1Group SCHIZOPHRENIA | GAF (All) | Month (All)

Ctime

600:00
480:00
360:00
240:00
120:00
0:00

55521 39126 47421 45090 41734 45346 35240 68011 35482 68964 57537 62557 67306 27764 252 68928 54291 34078 36527 40760 83226 80207 40591 46064 68091 74528 45109 83361 77225 51401

N

43169 47962 72352 72088 47654 45773 54225 22669 35930 59155 20161 47897 32537 45474 36607 28118 45945 46483 45605 48252 46830 45681 7379 35147 33622 43485 54826 62241 50421 12276

Y

MDCD | Case

Service
- Telemedicine
- MR Continuity
- Psych Evaluation
- MR Assessment
- Rehab Authorization
- MR Supported Emp
- MH Assessment
- MR Psychological
- Screening/Triage
- Diagnostics
- Case Coordination
- Nursing Svs
- Med Check
- Case Management
- Group Rehab
- Rehab Training
- Vocational Training
- MR Training

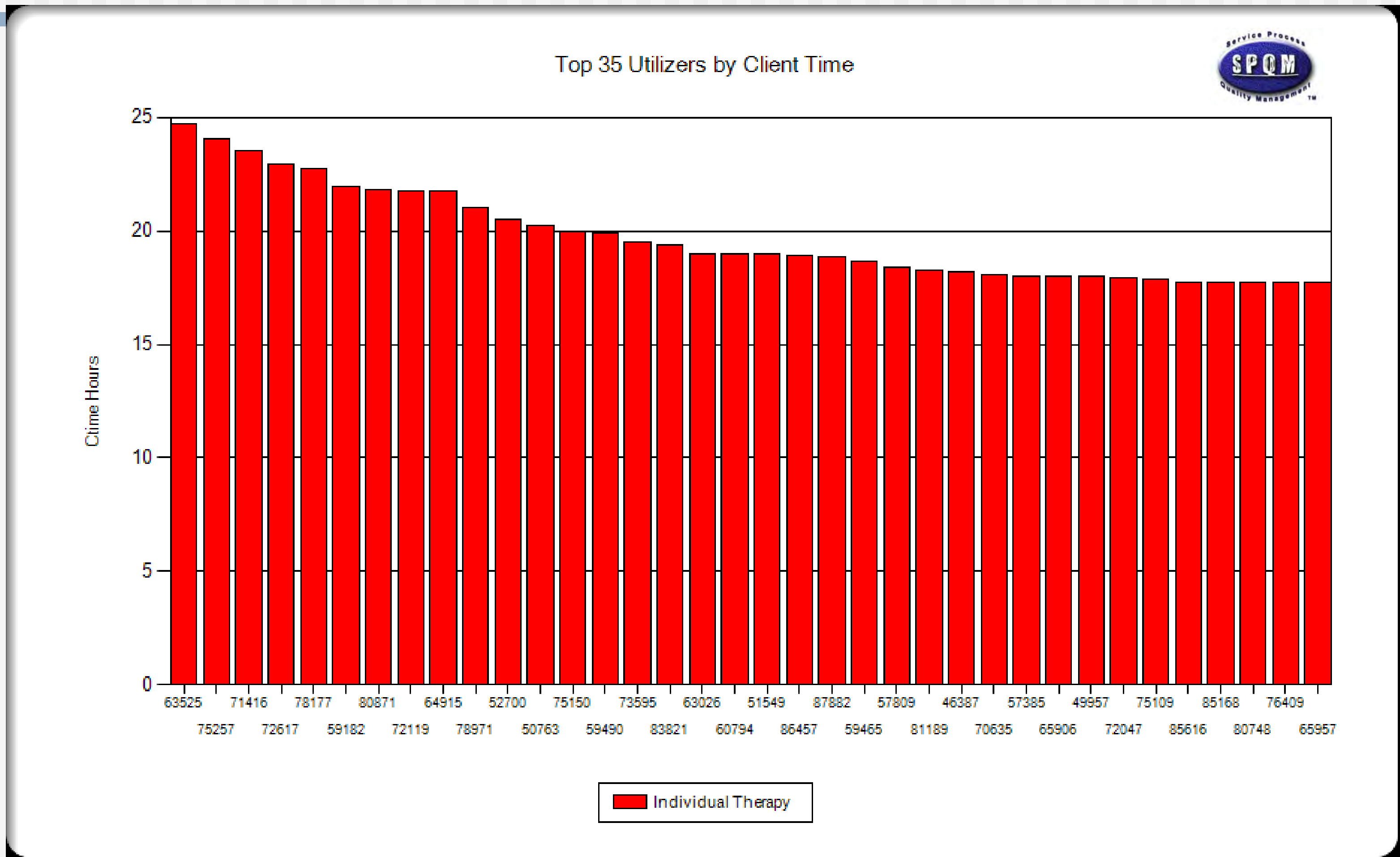
| Diag1Group | ANXIETY DX | Population | Adult | MDCD | All | Year | All | Month | All | Unit | All | Service | All |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

Events

GAF: 49, 48, 47, 46, 45, 44, 43, 42, 41, 40

Case

# Individual Therapy Outliers for Six Month Trend – Are Services Ordered in Plan?



# Collateral Intervention – Practice Variance

Average Clime Minutes

Events

Service Process SPQM Quality Management™

# Medication Administration Practice Variance

Average Clime Minutes
20
15
10
5
0
1653
155
78
59
43
38
15
14
5
4
2
2
1
1
5 5 5 7 14 5 15 15 15 15 15 19 15 15
1646.47
1636.47
141
131
121
111
101
91
81
71
61
51
41
31
21
11
1
Events
Service Process Quality Management
SPQM
TM
Coates, Joe
Grace, Donna
Leyva, Joe
Escoe, Andi
Tyler, Martin
McDonald, Larry
Wylie, Jack
Bass, Karen
Boone, Justine
Allison, Stan
Conner, Alice
Winslow, Barton
Anderson, Kelly
Faris, Naomi

Presented By:
David Lloyd, Founder

# Case Management Office Practice Variance

# Client Counts for Medicaid – NOS and Unspecified Concerns

| Duplicated Counts of Persons Served | | 2004 | | | | |
|---|---|---|---|---|---|---|
| | | 5 | 4 | 3 | 2 | 1 |
| ABUSE-NEGLECT DX | | 51 | 60 | 50 | 41 | 35 |
| ADD-HYPERACTIVITY DX | | 517 | 500 | 519 | 469 | 458 |
| ADJUSTMENT DX | ADJUSTMENT DISORDER UNSPECIFIED | 78 | 79 | 93 | 88 | 75 |
| | ADJUSTMENT DISORDER W/MIXED DISTURBANCE OF EMOTION | 232 | 227 | 225 | 228 | 203 |
| | ADJUSTMENT DISORDER WITH ANXIETY | 58 | 53 | 49 | 54 | 42 |
| | ADJUSTMENT DISORDER WITH DEPRESSED MOOD | 96 | 108 | 109 | 98 | 90 |
| | ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT | 44 | 46 | 37 | 39 | 29 |
| | ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESS | 182 | 193 | 193 | 164 | 170 |
| | POST TRAUMATIC STRESS DISORDER | 268 | 251 | 282 | 268 | 263 |
| | SEPARATION ANXIETY DISORDER | 7 | 3 | 3 | 2 | 4 |
| | | 965 | 960 | 991 | 941 | 876 |
| ALCOHOL RELATED DX | | 34 | 24 | 25 | 20 | 26 |
| AMNESTIC DX | | | | | | 1 |
| AMPHETAMINE RELATED DX | | 6 | 3 | 6 | 2 | 5 |
| ANXIETY DX | | 380 | 417 | 445 | 370 | 383 |
| ASPERGER'S DISORDER | | 52 | 49 | 47 | 45 | 49 |
| AUTISTIC DISORDER | | 5 | 3 | 4 | | 1 |
| BIPOLAR DX | | 366 | 375 | 400 | 342 | 359 |
| BORDERLINE PERSONALITY | | 1 | 3 | 3 | 4 | 3 |
| COGNITIVE DISORDER | | | | 1 | | |
| COMMUNICATION DX | | | 1 | 1 | 4 | 1 |
| DEMENTIAS | | 2 | 3 | 2 | 1 | 4 |
| DEPENDENT PERSONALITY | | | 1 | | | |
| DEPRESSIVE DISORDER NOS | | 463 | 455 | 486 | 426 | 396 |
| DISSOCIATIVE DX | | 2 | 2 | 2 | 3 | 2 |
| DX DEFERRED | | 7 | 8 | 8 | 6 | 5 |
| DYSTHYMIA | | 199 | 210 | 245 | 204 | 216 |
| EATING DX | | 1 | 2 | 1 | 3 | 4 |
| ELIMINATION DX | | 3 | 5 | 5 | 1 | 1 |
| FACTITIOUS DX | | | | | | |
| IMPULSE CONTROL DX | | 205 | 223 | 214 | 203 | 188 |
| LEARNING DX | | | | 2 | 1 | |
| MAJOR DEPRESSION | | 814 | 862 | 906 | 829 | 848 |
| MEDICALLY RELATED DX | | 35 | 38 | 49 | 40 | 36 |

# Practice Variance for CM Offsite by Diagnostic Group

| | Total Year | | | |
|---|---|---|---|---|
| | 2004 | | Total | |
| Diag 1 Group | Avg Ctime | Clients | Avg Ctime | Clients |
| TIC DISORDER | 1.1 | 2 | 1.1 | 2 |
| ABUSE-NEGLECT DX | 1.1 | 8 | 1.1 | 8 |
| EATING DX | 1.1 | 1 | 1.1 | 1 |
| MAJOR DEPRESSION | 1.0 | 92 | 1.0 | 92 |
| ANXIETY DX | 0.9 | 73 | 0.9 | 73 |
| ASPERGER'S DISORDER | 0.9 | 15 | 0.9 | 15 |
| ADJUSTMENT DX | 0.9 | 207 | 0.9 | 207 |
| IMPULSE CONTROL DX | 0.9 | 80 | 0.9 | 80 |
| OTHER CHILDHOOD DX | 0.9 | 71 | 0.9 | 71 |
| MOOD DISORDER | 0.9 | 20 | 0.9 | 20 |
| DYSTHYMIA | 0.8 | 18 | 0.8 | 18 |
| ADD-HYPERACTIVITY DX | 0.8 | 152 | 0.8 | 152 |

# Compliance is a CQI Process NOT and EVENT….

- **Quality Improvement Process Focus (QI)** – Typically Supports Process/Lack of Forward Movement/ Attainment

Vs.

- **Continuous Quality Improvement Solution Focus (CQI)** – Implies Movement Forward/Action Has Happened to Provide Continuous Improvement

MTM Services

# Rapid Cycle Improvement - Plan Do Study Act (PDSA) Cycles

- Establish the Parameters for the change.

1. Plan

- Implement the planned changes.

2. Do

3. Study

- Evaluate the effectiveness of the change.

4. Act

- React to the results of the evaluation.

The Deming Cycle, Deming's wheel, or the PDSA cycle is a long time utilized continuous quality improvement change philosophy created as part of W. Edwards Deming's Total Quality Management process (TQM) in the 1950's. Deming's work was based off of the Plan, Do and See cycle created by Mr. Walter A. Shewart in the 1920's, and has created successful change initiatives across multiple industries.

## Compliance is Like a Funnel...

- Outlier Management will continue to reduce the number of outliers IF the clinical managers and clinical staff are in the CQI loop...

# Questions and Feedback

- Questions?
- Feedback?
- Next Steps?