

POLICY AND PROCEDURE

DEPARTMENT: Integrated Care Management Quality Department	DOCUMENT NAME: Behavioral Health Provider Quality Monitoring Program
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PRODUCT TYPE: Medicaid	REFERENCE NUMBER: LA.QI.35

Provider Quality Monitoring Plan

The MCO shall develop and implement a plan for monitoring specialized behavioral health providers and facilities across all levels of care, which incorporates onsite reviews and member interviews. The MCO shall submit the plan to LDH for approval within 30 calendar days of contract execution and 60 days prior to revision. The MCO's plan shall comply with all the requirements as specified by LDH:

- Review criteria for each applicable provider type/level of care;
- Sampling approach including number and percent of onsite audits by provider type, number and percent of desktop audits, and number of charts to be reviewed at each provider location;
- Member interview criteria;
- Random audit selection criteria;
- Tools to be used;
- Frequency of review, including schedule of reviews by provider type;
- Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;
- Plan for ensuring corrective actions are implemented appropriately and timely by providers
- Inter-rater reliability testing methods.

At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient/residential. Additional levels of care may be added at the discretion of LDH.

The MCO's review criteria shall address the following areas at a minimum:

- Quality of care consistent with professionally recognized standards of practice;
- Adherence to clinical practice guidelines;
- Member rights and confidentiality, including advance directives and informed consent;
- Cultural competency;
- Patient safety;
- Compliance with adverse incident reporting requirements;
- Appropriate use of restraints and seclusion, if applicable;
- Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for the enrollee and includes goals. Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member;
- Continuity and coordination of care, including adequate discharge planning

RFP Reference: Provider Monitoring Plan and Reporting 14.9

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Provider Monitoring Plan

Professional Standards of Practice Observed

It is the policy of the MCOs to measure compliance with Behavioral Health Provider Monitoring Standards and standards as outlined by the National Commission of Quality Assurance. The Behavioral Health Provider Monitoring Process of the MCOs will endeavor to facilitate appropriate utilization of health care resources for members through review, analysis, and evaluation of medical, evaluation, treatment, and maintenance provided by Behavioral Health Service Providers included in the care of the member. The MCOs require ongoing monitoring of treatment records and agency requirements of a statistically significant sample size of all in-network Specialized Behavioral Health Service (SBHS) providers to ensure compliance with established state and federal guidelines and regulations. SBHS providers sampled must meet 80% overall for treatment records and agency requirements to be deemed passing or be subject to a corrective action plan. Treatment records are to be maintained in a manner that is current, detailed, organized, and which permits effective and confidential member care as well as quality review. The Provider Quality Monitoring Review will include the following, but is not limited to: adherence to clinical practice guidelines; adherence to agency specific requirements, member rights and confidentiality, including advance directives and informed consents; cultural competency; member safety; compliance with adverse incident reporting requirements; appropriate use of restraints and seclusions; treatment planning components; adequate discharge planning; and continuity and coordination of care. Treatment Records should reflect all services provided directly by the LMHP, physician, specialist, and any other practitioners, including non-licensed staff, and should include ancillary services and diagnostic tests ordered by the practitioner, and the diagnostic and therapeutic services for which the practitioner referred the member.

The MCOs, in compliance with the Health Insurance Portability and Accountability (HIPPA) Privacy Rule (45 C.F.R. § 164.530(i), develop and implement this written policy and procedure to protect members protected health information (PHI). This policy establishes and implements a process for treatment record requests that limit the use and disclosure of PHI to that which is the minimum amount reasonably necessary to achieve the intended purpose of the use, disclosure, or request. (Refer to 45 C.F.R. §§ 164.502(b) and 164.514 (d.) Member's treatment records must be treated as confidential information and accessible only to authorized persons. Treatment records for all members evaluated or treated should be safeguarded against loss, destruction or unauthorized use, maintained in an organized fashion, and readily accessible and/or available for review and audit to comply with company standards, provider specific contracts, and in accordance with Louisiana Revised Statue § 40:1165.1 (2015).

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The MCOs establish policies and procedures, performance measures, and goals to evaluate treatment record keeping practices and addresses confidentiality, maintenance, and availability of quality treatment records through provider contracts accessible to appropriate staff. Each MCO will conduct meetings as needed to review results and address any identified issues and/or concerns that may potentially require additional referrals.

MCO employees completing reviews

- Employees who can complete reviews are:
 - LMHPs as defined in the BHS Provider Manual:
 - Medical psychologists
 - Licensed psychologists
 - Licensed Clinical Social Workers (LCSWs)
 - Licensed Professional Counselors (LPCs)
 - Licensed Marriage and Family Therapists (LMFTs)
 - Licensed Addiction Counselors (LACS)
 - APRNs (must be a nurse practitioner (NP) specialist in adult psychiatric and mental health, and family psychiatric and mental health or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health, and may practice to the extent that services are within the APRN's scope of practice)

Staff Training

Each MCO conducts ongoing staff training and education on identified trends, best practices, and opportunities for improvement.

Tools Utilized

The MCOs will utilize the following tools for the review process:

- LDH-OBH audit template tool Behavioral Health Provider Monitoring Tool Elements and Agency Specific Requirements Guidelines specific to clinical components of the agency (Attachment A).
 - Elements are available for providers to review in the following locations: Links will be added once received from each MCO
 - Aetna:
 - AmeriHealth Caritas:
 - HealthyBlue:
 - Louisiana HealthCare Connections:

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<https://www.louisianahealthconnect.com/providers/resources/provider-toolkits.html>

- United Healthcare:
 - Medical Record Review Scorecard
 - Clinical Practice Guidelines Checklist as developed per each individual MCO.
 - Notification of Deficiencies Letter
 - Corrective Action Plan Template specific to each individual MCO.

Tools will be reviewed by the MCOs at minimum on an annual basis but not more than quarterly to make any needed changes.

Inter-rater reliability

At minimum the MCOs complete an IRR process, completed by an LMHP, annually which includes review of a sample of reviewer records to ensure consistency and reliability of results. Failure to meet a 90% for IRR will result in the reviewer being referred for corrective action according the individual MCO internal policies and procedures. The reviewer will not be able to independently review records until a score of 90% is reached.

Provider Type reviewed

Provider types reviewed will include:

- Mental Health Outpatient providers/practitioners
 - Individual/Group Practice (Psychiatrist, Psychologist, LPC, LMFT, LCSW, LAC, APRN)
 - CPST/PSR Agencies,
 - Other agency types (LGE, FQHC, RHC, Group Outpatient, and other outpatient provider types such as peer support specialists)
- Substance Use Outpatient
 - Opioid Treatment Providers (OTPs)
 - All substance Use Treatment Outpatient Providers – Individual/Group Practice LACs and all ASAM Levels
- Inpatient/Residential
 - Inpatient Psychiatric
 - Therapeutic Group Homes (TGH)
 - Psychiatric Residential Treatment Facilities (PRTF)
 - Inpatient Substance Use Treatment
 - Residential Substance Use Treatment

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*ACT, MST, FFT, Homebuilders are excluded providers from the quality monitoring due to separate fidelity reviews.

Frequency of Reviews

The Provider Monitoring process is continuous throughout the year. The MCOs will ensure providers are not reviewed more than once within a 12 month period unless the MCO identifies cause for a re-review.

Sampling Approach

At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient/residential. Additional levels of care may be added at the discretion of LDH.

The MCOs will utilize a random sample generator for unique member selection based off claims and/or authorizations identified during the 12 month period prior to the review quarter. In addition to the providers identified by the random sample, any providers who were involved in Adverse Incidents and/or Quality of Care investigations may be added to the sample pool for quality monitoring review (if not already part of the generated sample.)

Providers selected may not be available to review if they have an active case with the Special Investigation Unit (SIU), thus impacting the total number of reviews completed for the quarter.

Records Audited

A reasonable number of records at each site shall be reviewed to determine compliance. A minimum of five (5) records per site will be reviewed. An exception may occur and less records reviewed if a selected provider has seen fewer than five (5) MCO members.

Time Frame for Monitoring and Reporting

Initial review request, via email, postal letter, and/or phone call is made and the provider is given 14 days to respond and/or schedule the review. If the MCO receives no response within the time frame allotted, each MCO will follow their own internal procedures for possible escalation and/or referral.

CPG Guidelines

The MCOs will review Clinical Practice Guidelines (CPGs) for the following diagnosis: Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Substance Use Disorder,

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Schizophrenia, Generalized Anxiety Disorder, Bipolar Disorder, Oppositional Defiant Disorder, Post Traumatic Stress Disorder, and Suicide Risk.

On-site vs. desk audits

Treatment record reviews will be conducted via desk reviews as well as onsite. Any planned onsite reviews will be completed in accordance with safety protocols within LDH guidelines.

Member Surveys

MCO will survey 5% of randomly selected members who have received services from the identified provider. 2 call attempts are made per identified member before moving on to the next identified member and/or a letter is sent requesting a response within 2 weeks. The MCO may send additional letters and/or attempt phone calls to engage the member.

Results Review

Each MCO will conduct meetings as needed to review results and address any identified issues and/or concerns that may potentially require additional referrals.

Identification of issues

Any reviewed provider that shows evidence of Fraud, Waste, Abuse, and/or potential quality of care concerns is referred to the appropriate internal investigations department within each MCO. Quality of care concerns will also be reported to LDH per MCO contract requirements. Each MCO will follow their own internal policies and procedures to address any identified issues/concerns.

Corrective Action Plans (CAPs)

Providers are placed on CAPS when overall scores are less than 80%. Subsequent reviews will be conducted by the MCOs through their corrective action plan process. Each MCO has their own unique process to handle corrective action plans.

Record Storage

All provider documentation obtained by the MCOs will first be scanned into a secure network drive only accessible to a selection of the MCO employees who require access to the drive for completion of PQMP reviews and QIC oversight. Each MCO will maintain and store records in accordance with their own internal policies and procedures.

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Provider Education

Beginning in February 2021 and continuing over four consecutive weeks, the MCOs will offer daily intensive trainings on the provider quality monitoring tool. Each day's training will be specific to an identified provider type. Upon completion of the four week training sessions, the MCOs will reevaluate provider need and draft a training schedule to be offered on specified dates and times. Future trainings will be developed and offered based on providers' need as well as when LDH Behavioral Health manual updates necessitate.

Trainings will also be offered upon provider request. Training attendance on the provider quality monitoring tool will be mandatory for any provider who fails to meet the overall 80% required to be considered passing for a review. Providers who fail a review will be required to work with the issuing MCO to coordinate a training to satisfy this requirement.

~~**SCOPE:** Louisiana Healthcare Connections Integrated Care Management department has developed and will implement this Provider Quality Monitoring (PQM) plan for monitoring specialized behavioral health (SBH) providers and facilities across all levels of care. This PQM plan will incorporate onsite and offsite reviews as well as member interviews.~~

~~**PURPOSE:** Medical record reviews are necessary to guarantee that we are utilizing current industry and organization standards, clinical guidelines and scopes of care; and to ensure compliance with client contracts, various accrediting organizations and governmental agencies. LHCC Quality Improvement Coordinators (QIC) will utilize the Behavioral Health Services Provider Manual as a reference. One of the most beneficial uses for medical record reviews is to measure quality of care. Medical record reviews are conducted in order to 1) recognize and reinforce positive process management and staff behaviors and 2) systematically identify areas of opportunities for improvement. Positively identified areas will be appropriately acknowledged; and opportunities for improvement will be used to further strengthen the clinical intervention model.~~

POLICY:

~~Louisiana Health Connections Behavioral Health Provider Quality Monitoring Program requires ongoing monitoring of treatment records and agency requirements of a statistically significant sample size of all in network Specialized Behavioral Health Service (SBHS) providers to ensure compliance with established state and federal guidelines and regulations. In accordance with the RFP, SBHS providers sampled must meet 80% overall for medical record review to be deemed passing or be subject to a corrective action plan. Medical~~

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~~records are to be maintained in a manner that is current, detailed, organized, and which permits effective and confidential member care as well as quality review. The Provider Quality Monitoring Review will include the following, but is not limited to: adherence to clinical practice guidelines; adherence to agency specific requirements, member rights and confidentiality, including advance directives and informed consents; cultural competency; patient safety; compliance with adverse incident reporting requirements; appropriate use of restraints and seclusions; treatment planning components; adequate discharge planning; and continuity and coordination of care.~~

~~**PROCEDURE:** Annually, LHCC will utilize the LA-328 SBHS Detailed Provider Report to generate a list of selected providers to review. An empirically tested formula will be utilized by LHCC Data Analyst to obtain a statistically relevant sample to deliver a 95% confidence level and +/- 5 confidence interval. Based off the aforementioned formula, the total number of in-network providers will be divided by 4 (four quarters within one year) to calculate the total number of providers per level of care spanning across all provider types to be reviewed quarterly.~~

~~Each quarter, priority selection will occur from those providers who have had Quality of Care (QOC) investigations completed and/or have submitted adverse incident reports that were deemed severe prompting a QOC referral. All remaining providers listed on the LA-328 SBHS Detailed Provider Report will be vetted by: any provider(s) termed, any provider(s) who have been reviewed within a 12 month period of the reviewing quarter will be removed from the list, and remaining providers will be separated by level of care spanning across all provider types for random selection to occur. LHCC Quality Improvement Coordinators (QIC) will perform 15% of quarterly total as onsite reviews.~~

~~LHCC Data Analyst will utilize a random sample generator to obtain members having received at least one service during the review quarter. LHCC QICs will review between 1 to 7 member medical records. For inpatient providers, the number of members selected will be based on members who have been discharged during reviewing quarter.~~

~~**1.0** — Medical record reviews are conducted by Behavioral Health QICs and results are trended by the Integrated Care Management Department to determine plan-wide areas in need of improvement. Areas of concern may be addressed network-wide and/or provider-specific, depending on~~

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~~need, utilizing best practices for education to improve which includes conducting complete, detailed and objective medical record reviews for analysis and quality improvement opportunities.~~

~~**1.1** — The LHCC BH Provider Quality Monitoring Program Operations Management is responsible for conducting complete, detailed and objective medical record reviews for analysis and quality improvement opportunities.~~

~~**1.1.1** — Member medical record reviews will include but is not limited to the purposes of utilization review, quality management, targeted review activity or quality improvement initiatives related to treatment record documentation standards~~

~~**1.1.2** — Assisting the LHCC Integrated Care Management Department in process identification, defining performance indicators, identifying barriers and interventions, success factors and risks;~~

~~**1.1.3** — Keeping the LHCC Integrated Care Management Department appraised of changes that affect those items;~~

~~**1.1.4** — Assisting LHCC QICs, as needed, with their review of Behavioral Health participant medical records; and~~

~~**1.1.5** — Scheduling and conducting refresher training with Behavioral Health Management Program Operations staff based on process or clinical issues identified by QICs and/or by the Senior Director of Integrated Care Management Department.~~

~~**2.0** — Medical record reviews may occur as part of a routine schedule (Quarterly) or can also be the result of a specific request. An “Action Medical Record Review” may be performed more frequently based on issues identified by LHCC Behavioral Health Program Operations Management, external customers, or anytime a special problem arises.~~

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~~**3.0** — LHCC Behavioral Health Provider Quality Monitoring Program participant medical records (charts), both electronic and paper components, will be used to support the ability to conduct self reviews or external review of documentation to determine variation from established baselines.~~

~~**3.1** — All medical records received will be maintained by LHCC for at least ten (10) calendar years. Medical records will be filed in to the Shared Drive under auditing quarter, provider name, and member name.~~

~~**3.2** — LHCC will provide one (1) free copy of any part of medical records received to its members upon member's request.~~

~~**4.0** — LHCC Behavioral Health Provider Quality Monitoring Program medical record reviews are used to:~~

~~**4.1** — Demonstrate performance oversight of compliance with the LHCC Behavioral Health Provider Quality Monitoring Program policies and procedures and accreditation standards.~~

~~**4.2** — Demonstrate compliance with job roles and scope of practice.~~

~~**4.3** — Evaluate the consistency in the application of criteria, data element selection and entry, and interpretation of policy.~~

~~**4.4** — Provide the basis for tracking and reporting of performance to the Quality Improvement Committee.~~

~~**5.0** — Findings will be integrated into the development of LHCC Behavioral Health Provider Quality Monitoring Program employee education programs, performance evaluations, and will be used for re-reviewing to ensure the effectiveness and consistency of operations and interventions.~~

~~**6.0** — LHCC Behavioral Health Provider Quality Monitoring Program's target performance goal is 80%. An overall review score of less than 80% will result in the development of a corrective action plan.~~

~~**6.1** — **The provider has met expectations if their overall review score is 80% or above.** The QIC will notify the project~~

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~~coordinator that the review is complete and the Provider has passed. The project coordinator will then send a “Thank You for Participating” letter to the Provider with the medical record review results.~~

~~**6.2** — The CAP process consists of the following:~~

~~**6.2.1** — A CAP letter will be sent to the provider to notify that expectations were not met via certified mail,~~

~~**6.2.2** — Suggestions and resources will be given for process improvement measures,~~

~~**6.2.3** — Progress will be monitored, and~~

~~**6.2.4** — The Provider will be re-reviewed within 6 months from initial medical record review date.~~

~~**6.2.4.1** — LHCC assigned QIC will generate scorecards by pulling the data from SharePoint.~~

~~**6.2.4.2** — The Provider will complete the CAP template, sign/date the CAP and scorecard, and return it to the QIC fax number provided on the CAP letter within ten (10) calendar days.~~

~~**6.2.5** — A Summary of Providers on a CAP will be sent to:
LHCC Senior Director of Integrated Care Management
LHCC assigned Project Coordinator
All QICs involved~~

~~**6.3** — Once the signed, dated, and completed CAP is received by the assigned QIC, the QIC will follow up with provider over the next 180 days to ensure implementation of the CAP.~~

~~**6.4** — Signed CAPs will be filed on the G:Drive by the Project Coordinator.~~

~~**6.5** — Calendar Invites will be created by the Project Coordinator as a~~

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~~reminder for the responsible QIC to contact the provider at least monthly to monitor progress until the 6 month re-review process.~~

~~7.0~~ Requesting Medical Records/Treatment Records

~~7.1~~ — Once the PQMP list has been compiled, outreaches will be conducted immediately to obtain medical records to perform the review.

~~7.2~~ — The QIC will make outreach to provider to confirm demographics, fax number, point of contact, and if provider on PQMP medical record review list is accurate. The QIC will log in all contacts made/attempted into Share Point and update as needed.

~~7.3~~ — The Project Coordinator will mail or fax the approved initial medical record request letter and the provider checklist to the confirmed mailing address or fax number addressed to the appropriate point of contact. *NOTE: Date, Address, and Quarter being reviewed will need to be updated for each provider.*

~~8.0~~ Retrieving Medical Records/ Treatment Records

~~8.1~~ — Providers will fax or mail medical records, or will be scheduled for an onsite medical record review as stated in the letter(s) (Letters Appendix B). QICs can obtain records via an EHR/EMR or secured portal if the provider allows access to QICs. Faxcom and mail will be monitored for incoming information submitted for medical record reviews and a records log will be updated, as needed. The notification letter(s) will be mailed to the providers on the 15th of last month in the quarter prior to medical record review.

~~8.2~~ — One week after the letter is sent, follow up calls will be completed to check on the status of the medical records by assigned the QIC. This interaction will be documented in Share Point.

~~8.2.1~~ — If provider states they did not receive the letter, another letter may be faxed to that provider, with immediate follow up. If provider states they did not receive the 2nd letter, a certified letter to the confirmed address may be

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sent.

~~8.3~~ — At least five (5) follow up calls (including the initial follow up call) will be completed for providers who are non-compliant in sending in medical records. This interaction will be documented in Share Point. A list of non-compliant providers will be sent to the Medical Affairs Committee at the end of each quarter for their review and advisement.

~~9.0~~ — Conducting the Behavioral Health PQMP Medical Record Review.

~~9.1~~ — The QICs will conduct a systematic examination of each member medical record using the audit tool.

~~9.2~~ — LHCC QICs will utilize the Behavioral Health Service Definition Manual and the 2020 PQMP Tool (Appendix A) which includes Agency Specific Requirements related to all provider types and level of care.

~~10.0~~ — Recoupment

~~10.1~~ — LHCC QICs reserve the right to refer providers to the Claims Department if the provider is on a CAP or are noncompliant.

~~10.2~~ — LHCC QICs reserve the right to refer providers to the Networking and Credentialing Department if the servicing provider is determined to NOT have appropriate licensure for the service provided.

~~11.0~~ — Post Audit Analysis and Reporting.

~~11.1~~ — At the end of each quarter, the Quality Review Team will:

~~11.2~~ — Run, analyze, and review the appropriate database reports associated with the most currently selected reporting indicators (*Note: Current reporting indicators may periodically change upon mutual agreement by LHCC QI and LHCC Behavioral Health Management Program Operations Departments*).

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~~11.3~~—The LHCC Integrated Care Management Department and LHCC Behavioral Health Provider Quality Monitoring Program Operations Departments will periodically discuss the inclusion of one or more additional reporting indicators based on time-sensitive needs.

~~11.4~~—The Senior Director, or designee will present current reported indicator audit findings to the Quality Improvement Committee and appropriate Behavioral Health Program Operations Management staff following a completed audit cycle; or another mutually agreed upon timeframe to address any identified anomalies.

~~11.5~~—The presentation shall include:

~~11.5.1~~—Quarter(s)/Year audit conducted.

~~11.5.2~~—Provider description (i.e. provider type, level of care, and number of records reviewed per provider).

~~11.5.3~~—Major findings—Summarize the most undesirable conditions and practices in order of their relative importance.

~~11.5.4~~—Opportunity for Improvement Observations. Give a detailed account of the current practices and list the opportunities for improvement in procedures, standards, documentation, safety, etc., along with the identity of relevant standards.

~~11.5.5~~—Positive observations. Identify areas that are being done particularly well.

~~11.6~~—The LHCC Behavioral Health Provider Quality Monitoring Program will review the report and make recommendations for appropriate actions to be taken, which may include but are not limited to:

~~11.6.1~~—Development of an action plan, improvement goal,

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~~and/or standard.~~

~~11.6.2~~ ~~Revise policies/procedures to clarify and prevent misunderstanding.~~

~~11.6.3~~ ~~Collaborate with other functional areas on issues identified having impact on clinical audit results.~~

~~11.6.4~~ ~~Provide additional training in identified areas in need of improvement.~~

~~11.6.5~~ ~~Disciplinary action, if necessary.~~

~~11.7~~ ~~All Corrective/Preventive Actions should be reviewed prior to implementation to ensure context of the finding is interpreted correctly.~~

~~11.8~~ ~~After Corrective/Preventive Actions are implemented, the LHCC QIC will verify the effectiveness of the actions taken and record the results in the Corrective/Preventive Action database.~~

~~11.9~~ ~~LHCC QICs will maintain all medical record review reports; ensure medical record review process is updated according to mutually identified interdepartmental needs; and maintain an archive of appropriate objective evidence of the medical record reviews.~~

~~12.0~~ ~~**LHCC Behavioral Health Medical Record Reviews conducted at the request of an external party:**~~

~~12.1~~ ~~The LHCC Behavioral Health Provider Quality Monitoring Program will notify the Quality Department of any requested external review.~~

~~12.2~~ ~~If the external organization requests that the Electronic Medical Record (EMR) be printed from a pre-identified list, the Medical Records staff will fulfill this request and make available to the~~

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~~DM/LM Management Program Operations staff at a pre-determined time and date prior to the medical record review (see below).~~

~~**12.3**— If the external organization has not requested the EHR be printed from a pre-identified list, the LHCC IT Department will assign temporary user IDs and passwords to the appropriate LHCC BH PQMP personnel assigned to assist the external reviewers.~~

~~**13.0**— LHCC Behavioral Health Provider Quality Monitoring Program will review member charts for:~~

~~**13.1**— Provider qualifications and requirements according to LHCC and Federal Guidelines, provider qualifications and LHCC requirements, LDH provider qualifications and requirements, state law requirements, and the individual staff level, and licensure.~~

~~**13.1.1**— The LHCC Provider Networking and Accreditation department will supply a roster of staff members for each servicing provider. LHCC QICs will verify the status of the current staff rosters through licensure websites, a current roster of staff, and staff personnel records.~~

~~**13.2**— The servicing provider's demographics associated with service location, telephone numbers, languages spoken appointment availability standards and admissions per contract stipulation.~~

~~**13.3**— LHCC shall make any collected information, monitoring reviews and findings, corrective action plans, and follow up available to LDH upon request in an LDH approved format.~~
















REFERENCES

EPC.COMP.025 Corrective/Preventive Action Program
CC.LEGL.01.02 Disposition of Records

ATTACHMENTS:

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Attachment A-2020 PQM Request Letter	Attachment B-2020 PQM Request Letter	Attachment C- COCMR. Onsite Con	Attachment D-2020 PQMP Tool Elements	Attachment E 2020 PQM Results Letter	Attachment F- 2020 PQM CAP Template
					
Attachment G-2020 Core and CPG Score	Attachment H- Agency Specific Req	Attachment I-2020 CAP Process Flowch	Attachment A – Behavioral Health Pr	Attachment B – Initial Review Reque	Attachment C – Initial Review Reque
					
Attachment D – Provider Scorecard.c	Attachment E – Provider Notificator	Attachment F – Provider Notificator			

DEFINITIONS:

- Medical Record Review-internal or external review of documentation to determine variation from established baselines.
- Deficiency analysis-process to review, track, and obtain completion for missing elements in documentation, such as reports and signatures.
- Electronic Health Record (EHR)-a computerized record of health information and associated processes.
- Medical Record-the legal medical record is the documentation of the services provided to an individual in any aspect of healthcare delivery and education. The legal medical record is individually identifiable data, in any medium, collected and directly used in and/or documenting healthcare or health status. The term includes specific records of care used by healthcare professionals while providing participant care services, for reviewing participant data, or documenting observations, actions, or instructions.

REVISION LOG

REVISION	DATE
<ul style="list-style-type: none"> • In Scope section, verbiage changed from “This PQM plan will incorporate onsite reviews and members interviews” to “This PQM plan will incorporate onsite and offsite reviews.” • In Purpose section and Procedure section 6.2, verbiage change due to redundancy. • Procedure section has been updated to match LHCC PQM Strategy specifically in opening paragraphs and sections 1, 3, 6, 7, 8, 9, 11, and 13. • Under procedure, section 3, addendums made including “3.1 	05/2019

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<p>All medical records received will be maintained by LHCC for at least ten (10) calendar years. Medical records will be filed in to the Shared Drive under auditing quarter, provider name, and member name. 3.2 LHCC will provide one (1) free copy of any part of medical records received to its members upon member's request."</p> <ul style="list-style-type: none"> • Under procedure, section 6.0, addendums made include "A score of less than 80% on Clinical Practice Guidelines may result in a QOC referral to QIC designee and/or development of a corrective action plan." • Attachments updated. 	
<ul style="list-style-type: none"> • Department changed from Quality Improvement to Integrated Care Management. • In Scope section, Quality Department changed to Integrated Care Management Department. • Quality Review Team Auditors changed to QI Auditors for continuity in verbiage throughout this document. • Section 1.0, Department changed from Quality Improvement to Integrated Care Management throughout entirety of section. • Section 1.1.5, Quality Review Manager changed to Senior Director of Integrated Care Management Department. • Section 6.2.5, Director Quality changed to Senior Director of Integrated Care Management. • 	08/2019
<ul style="list-style-type: none"> • Under procedure, section 6.0, removal of addendum previously made include "A score of less than 80% on Clinical Practice Guidelines may result in a QOC referral to QIC designee and/or development of a corrective action plan." 	9/2019
<ul style="list-style-type: none"> • Per LDH's advisement, the word audit has been changed to medical record review and QI Auditors have been changed to QICs. • Per LDH's advisement, the SBH Service Definition Manual being utilized as a reference while reviewing medical records has been added in the verbiage found under Purpose. • Per LDH's advisement changes in verbiage were made in the following sections: Purpose, Policy, and Procedure. 	12/2019
<ul style="list-style-type: none"> • Updated years referencing 2019 throughout policy and its attachments to reflect 2020 templates. 	12/19/19

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<ul style="list-style-type: none"> Added verbiage under Policy: “The Provider Quality Monitoring Review will include the following, but is not limited to: adherence to clinical practice guidelines; member rights and confidentiality, including advance directives and informed consents; cultural competency; patient safety; compliance with adverse incident reporting requirements; appropriate use of restraints and seclusions; treatment planning components; adequate discharge planning; and continuity and coordination of care.” 	
<ul style="list-style-type: none"> Adjusted verbiage under Policy section and Procedure section, 6.0 to reflect suggestions given by LDH. 	01/20
<ul style="list-style-type: none"> The word Overall included in the following sentence as suggested: “In accordance with the RFP, SBHS providers sampled must meet 80% overall for medical record review to be deemed passing or be subject to a corrective action plan.” 	4/20
<p><u>Based on feedback obtained from the approved LA356 all MCO Provider Quality Monitoring Strategy, changes made within this policy include the following:</u></p> <ul style="list-style-type: none"> <u>Add (LHCC) after first mention of Louisiana Health Connections under Scope</u> <u>All verbiage that stated “medical record” was changed to “treatment record”</u> <u>Added “to measure compliance with Behavioral Health Provider Monitoring Standards and standards as outlined by the National Commission of Quality Assurance (NCQA). The Behavioral Health Provider Monitoring Process will endeavor to facilitate appropriate utilization of health care resources for members through review, analysis, and evaluation of medical, evaluation, treatment, and maintenance provided by Behavioral Health Service Providers included in the care of the member. LHCC requires ongoing monitoring of treatment records” under policy section.</u> <u>Edited verbiage under Policy to include “In accordance with the RFP, SBHS providers sampled must meet 80% overall for treatment record and agency clinical requirements review to be deemed passing or be subject to a corrective action plan (CAP).”</u> <u>Added verbiage under Policy to include: ” quality of care provided being consisted with professionally recognized standards of practices;”</u> 	<u>02/21</u>

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- Added under Policy: “Treatment records should reflect all services provided directly by the Licensed Mental Health Professional (LMHP), physician, specialist, and any other practitioners, including non-licensed staff, and should include ancillary services and diagnostic tests ordered by the practitioner, and the diagnostic and therapeutic services for which the practitioner referred the member.”
- Added under Policy: “In compliance with the Health Insurance Portability and Accountability (HIPPA) Privacy Rule (45 C.F.R. § 164.530(i), LHCC will develop and implement this written policy and procedure to protect members’ protected health information (PHI). This policy establishes and implements a process for treatment record requests that limit the use and disclosure of PHI to that which is the minimum amount reasonably necessary to achieve the intended purpose of the use, disclosure, or request. (Refer to 45 C.F.R. §§ 164.502(b) and 164.514 (d.) Member's treatment records must be treated as confidential information and accessible only to authorized persons. Treatment records for all members evaluated or treated should be safeguarded against loss, destruction or unauthorized use, maintained in an organized fashion, and readily accessible and/or available for review and audit to comply with company standards, provider specific contracts, and in accordance with Louisiana Revised Statute § 40:1165.1 (2015).”
- Added the following verbiage under Procedure:
“At a minimum, LHCC’s sampling approach will result in a statistically significant representative sample with a confidence interval of 95% + or -5 for each level of care. The sample will be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient/residential. Additional levels of care may be added at the discretion of the LDH. Providers excluded from the PQMP due to having a separate fidelity review include: ACT, MST, FFT, and Homebuilders.”
“LHCC will utilize a random sample generator for unique member selection based off claims and/or authorizations identified during the 12 month period prior to the review quarter. In addition to the providers identified by the random sample, any providers who were involved in Adverse Incidents and/or Quality of Care investigations may be added to the sample pool for quality monitoring review (if not already part of the generated sample.)”
“Providers selected may not be available to review if they have an

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<p><u>active case with the Special Investigation Unit (SIU), thus impacting the total number of reviews completed for the quarter. Additionally, those providers who may have been terminated will be removed the list. LHCC will ensure providers are not reviewed more than once within a 12 month period unless there is cause for a re-review. Treatment record reviews will be conducted via desk reviews as well as onsite. Any planned onsite reviews will be completed in accordance with safety protocols within LDH and LHCC guidelines.”</u></p> <p><u>“a minimum of five (5) records per site to determine compliance. An exception may occur and less records reviewed if a selected provider has seen fewer than five (5) members. LHCC will survey 5% of those randomly selected members who have received services from the identified provider whereby an initial survey will be mailed to the selected member along with prepaid postage and self-addressed envelope to send back to LHCC within a requested fourteen (14) calendar day time frame. LHCC will send additional surveys via mail as needed to promote member engagement in the survey.”</u></p> <ul style="list-style-type: none"> • <u>Removed the following from Procedure section:</u> <p><u>“An empirically tested formula will be utilized by LHCC Data Analyst to obtain a statistically relevant sample to deliver a 95% confidence level and +/- 5 confidence interval. Based off the aforementioned formula, the total number of in-network providers will be divided by 4 (four quarters within one year) to calculate the total number of providers per level of care spanning across all provider types to be reviewed quarterly.”</u></p> <p><u>“Each quarter, priority selection will occur from those providers who have had Quality of Care (QOC) investigations completed and/or have submitted adverse incident reports that were deemed severe prompting a QOC referral. All remaining providers listed on the LA-328 SBHS Detailed Provider Report will be vetted by: any provider(s) termed, any provider(s) who have been reviewed within a 12 month period of the reviewing quarter will be removed from the list, and remaining providers will be separated by level of care spanning across all provider types for random selection to occur. LHCC Quality Improvement Coordinators (QIC) will perform 15% of quarterly total as onsite reviews.”</u></p> <p><u>“between 1 to 7 member medical records.”</u></p> <p><u>“For inpatient providers, the number of members selected will be based on members who have been discharged during reviewing quarter.”</u></p> • <u>Added the following in Section 1.0: “LHCC QICs conducting treatment record reviews are LMHPs as defined within the</u> 	
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<p><u>Behavioral Health Services Provider Manual. LHCC conducts ongoing staff training and education on identified trends, best practices, and opportunities for improvement to QICs.”</u></p> <ul style="list-style-type: none"> • <u>Added 6.0 “Any reviewed provider that shows evidence of Fraud, Waste, Abuse, and/or potential quality of care concerns is referred to the appropriate internal investigations department. Quality of care concerns will be reported to LDH per contract requirements.</u> • <u>Section 7.1 verbiage “project coordinator that the review is complete and the Provider has passed. The project coordinator will then send a thank you for participating letter to the provider with the medical record review results” replaced with “The QIC will notify the provider of passing score via results letter and itemized scorecard of their results. LHCC will offer an opportunity to review results and address any identified issues and/or concerns to providers upon their request.”</u> • <u>Added verbiage to 7.2 “The provider has not met expectations if their overall review score is less than 80% resulting in a CAP.”</u> • <u>Added verbiage to 7.2.1 “and itemized scorecard”</u> • <u>In section 7.2.4, replaced “6 months” with “180 calendar days from initial treatment record review”</u> • <u>Removed 6.2.4.1 “LHCC assigned QIC will generate scorecards by pulling the data from SharePoint”.</u> • <u>Added verbiage to section 7.2.4.1 “Extensions will be granted within reason when requested by the provider”.</u> • <u>Added 7.2.4.2 “If the provider fails to submit their CAP in a timely manner, they will be reported to LHCC Medical Director to be discussed at the Provider Engagement Committee to determine what actions should be taken.”</u> • <u>Removed Project Coordinator from 7.4, 7.5, and 8.3.</u> • <u>Replaced “6 month re-review process” to “the re-review conducted within 180 calendar days from the original review date” in section 7.5</u> • <u>Added 7.5.1 “The provider will have up to 60 calendar days from the data of the CAP notification to implement CAP interventions.”</u> • <u>Added 7.6 “If the provider fails to score an overall 80% or above on the re-review, they will be referred to the LHCC Provider Engagement Committee to determine next steps which could include termination from the network.”</u> 	
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- In section 8, changed tracking updates within “SharePoint” to “tracking log”
- 9.1 Edited verbiage from “Providers will fax or mail medical records or will be scheduled for an onsite medical record review as stated in the letter(s)” to “Providers will fax or mail treatment records to the assigned QIC identified on the initial request letter. Treatment record reviews will be conducted via desk reviews as well as onsite. Any planned onsite reviews will be completed in accordance with safety protocols within LHCC and LDH guidelines.”
- 9.1 section, changed “notification” to “initial request”. Added “faxed and/or mailed to providers by the 15th”.
- 9.2 Replaced SharePoint with “responsible QIC’s tracking log”.
- 9.2.1 added “If provider states they still did not receive the letter, LHCC QIC will have LHCC Provider Consultant assigned to that region assist in delivering letter.”
- 9.3 added “and attempt made by Provider Consultant”; “and/or non-responsive”; and the list of non-compliant providers will be sent to “LHCC Medical Director and the Medical Affairs Committee for their review and advisement”. Removed “At the end of each quarter”.
- Added 9.4 “All provider documentation obtained by LHCC will be scanned and stored into a secure network drive only accessible to a selection of LHCC employees who require access to the drive for completion of PQMP treatment record reviews and QIC oversight.”
- Replaced the following in section 10.2 “and the 2020 PQMP Tool which includes Agency Specific Requirements related to all provider types and level of care” with “LHCC QICs will utilize the following, but is not limited to: Behavioral Health Service Provider Manual, the LDH-OBH approved Behavioral Health Provider Monitoring Tool Elements and Agency Specific Requirements Guidelines specific to clinical components of the agency, the LDH-OBH approved PQMP review tool template, the LDH-OBH approved PQMP scoring rubric, treatment record review scorecard and initial requests as well as results’ letters, and CAP template.”
- Added 10.3 “ Tools utilized for the PQMP will be reviewed by LHCC at a minimum on an annual basis, but not more than quarterly to make changes needed.”
- Section 12.4 Changed “audit” to “review”
- Section 12.8.1 moved the following verbiage from section 13 “LHCC shall make any collected information, monitoring reviews and

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<p><u>findings, corrective action plans, and follow-up available to LDH upon request in an LDH approved format.”</u></p> <ul style="list-style-type: none"> • <u>Section 13.2 changed “Medical Records staff” to “assigned staff”</u> • <u>Removed previous section 13 due to being laid out in earlier section, which included:</u> <u>“LHCC Behavioral Health Provider Quality Monitoring Program will review member charts for: Provider qualifications and requirements according to LHCC and Federal Guidelines, provider qualifications and LHCC requirements, LDH provider qualifications and requirements, state law requirements, and the individual staff level, and licensure.</u> <u>LHCC Provider Networking and Accreditation department will supply a roster of staff members for each servicing providers. LHCC QICs will verify the status of the current staff rosters through licensure websites, a current roster of staff, and staff personnel records. The servicing provider’s demographics associated with service location, telephone numbers, languages spoken appointment availability standards and admissions per contract stipulation”.</u> • <u>Added 14.0 IRR Testing:</u> • <u>“Inter-rater reliability (IRR) testing: At minimum, LHCC will complete an IRR process, completed by an LMHP annually which includes review of a sample of reviewer records to ensure consistency and reliability of results.</u> <u>The assigned LMHP will sample at least 10 reviewer records. Failure to meet a score of at least 90% for IRR will result in the reviewer being referred for corrective action which can include coaching up to termination.</u> <u>The reviewer will be required to attend retraining and successfully retest within 30 calendar days of the retraining.</u> <u>The reviewer will not be able to independently review records until a score of 90% is reached.”</u> • <u>Added 15.0 Provider Training:</u> <u>“Provider Training: Beginning in February 2021 and continuing over four consecutive weeks, LHCC will offer intensive trainings on the provider quality monitoring tool. Each training will be specific to an identified provider type requiring PQMP review.</u> <u>Upon completion of the four week training sessions, LHCC will meet with the other MCOs to reevaluate provider need for further training and draft a training schedule to be offered on specified dates and times.</u> <u>Future trainings will be developed and offered based on providers’</u> 	
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<p><u>need as well as when LDH Behavioral Health manual updates necessitate.</u></p> <p><u>Trainings will also be offered upon provider request and if provider fails to meet the overall 80% passing threshold.</u></p> <p><u>Training attendance on the provider quality monitoring tool will be mandatory for any provider who fails to meet the overall 80% required to be considered passing for a review.</u></p> <p><u>Providers who fail a review will be required to work with LHCC to coordinate a training to satisfy this requirement.”</u></p> <ul style="list-style-type: none"> • <u>Replaced Attachments A-I 2020 with Attachments A-M 2021</u> • <u>Integrated Care Management Department changed to Quality Department in header; under Scope; under Procedure sections 1.0, 1.1.2, 1.1.3; Section 12.3</u> • <u>Senior Director of Integrated Care Management Department changed to Senior Director of Quality Department under Procedure Section 1.1.5 and 7.2.5.</u> 	
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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to a physical signature.

Vice President of Medical Management: Approval on file

Sr. VP, Medical Affairs: Approval on file