



DHHS Post-Payment Review Tool for Providers - Generic Guidelines

REVIEW ITEM WITH SUPPORTING CITATIONS:	REVIEW GUIDELINES:	HIGHEST LEVEL OF ACTION POSSIBLE: PB = Payback ED = Plan of Correction ED = Educational
<p>1. Is there evidence the provider agency meets the access standards related to appointment availability (emergency, urgent and routine need)?</p> <p>42CFR 438.206 (1)(i) Timely access. Each MCO, PHP, and PAHP must do the following: Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.</p> <p>DMA Contract Attachment S P/HP shall ensure that Network Providers meet the following Access Standards related to Appointment Availability:</p> <ol style="list-style-type: none"> 1. Emergency Services – Providers must provide face-to-face emergency services within two hours after a request for emergency care is received by Provider staff from the P/HP or directly from an Enrollee; the Provider must provide face-to-face emergency care immediately for life threatening emergencies; 2. Urgent Need Services -- Providers must provide initial face-to-face assessments and/or treatment within forty-eight hours after the date and time a request for urgent care is received by Provider staff from the P/HP or directly from an Enrollee; 3. Routine Need Services -- Providers must provide initial face-to-face assessments and/or treatment within fourteen (14) calendar days of the date a request for routine care is received by Provider staff from the P/HP or directly from an Enrollee; 	<p style="text-align: center;">AGENCY ACCESS AND AVAILABILITY</p> <p>Sample: 10 service referrals. The LME/MCO will not go back more than one year from the date of notification of the review to obtain a sample of the 10 service referrals. This item will be agency specific.</p> <p>Evidence: The agency must demonstrate that access standards related to appointment availability (emergency, urgent and routine needs) are followed.</p> <p>Review the agency's policy and procedure manual addressing access standards and appointment availability.</p> <p>The LME/MCO will review the enrollee's service record to determine whether the service was provided within the guidelines established for emergency, urgent or routine need.</p> <p>Applies to the following services:</p> <p>Enhanced: Mobile Crisis, Diagnostic Assessment, IH*, MST*, CST*, PSR*, Day Treatment*, Partial Hospitalization*, SAIOP, SACOT, Ambulatory Detox, Outpatient Opioid;</p> <p>*For Intensive In Home this item will only be reviewed for routine need services. *For MST this item will only be reviewed for routine need services. *For CST this item will only be reviewed for routine need services. *For PSR this item will only be reviewed for routine need services. *For Day Treatment this item will only be reviewed for routine need services. *For Partial Hospitalization this item will only be reviewed for routine need services.</p> <p>Innovations: None.</p> <p>DMH/DD/SAS State-Funded Enhanced MH/SA Services – refer to service definitions for specifics. Existing State-Funded DMH/DD/SAS Services – refer to service definitions for specifics</p>	<p>POC</p>



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2.	<p>Is there evidence the provider agency meets the access standards related to Office Wait Time (scheduled, walk-ins and emergency)?</p> <p>42CFR 438.206 (1)(ii) – Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees</p> <p>DMA contract, Attachment S PIHP shall ensure that Network Providers meet the following Access Standards related to Office Wait Time:</p> <ol style="list-style-type: none"> 1. Scheduled Appointments – Sixty minutes after the appointed meeting time; 2. Walk-ins – within two hours after the Enrollee's arrival. If that is not possible, staff must schedule an appointment for the next available day; 3. Emergencies - PIHP staff shall ensure that Enrollees are provided face-to-face emergency care within two hours after the request for care is initiated by PIHP or directly by the Enrollee; life threatening emergencies shall be managed immediately. 	<p>Sample Size: N/A</p> <p>Evidence: Review the agency's office wait time policy and procedure manual.</p> <p>The agency's policy and procedure manual should include steps the agency will take to address situations which prevent adherence to the office wait time standards to include immediate notification of the enrollee when office wait times have been exceeded, estimated wait time and reason for delay.</p> <p>Provider will make available documentation/data specific to complaints/concerns for the review period selected. LME/MCO will review provider's documentation/data to determine whether there are complaints related to office wait times.</p> <p>Applies to the following services:</p> <p>Enhanced: Diagnostic Assessment, SAIOF, SACOT, Ambulatory Detox and Outpatient Opioid</p> <p>Innovations: None</p> <p>DMH/DD/SAS State-Funded Enhanced MH/SA Services – refer to service definitions for specifics. Existing State-Funded DMH/DD/SAS Services – refer to service definitions for specifics</p>	POC



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3.	<p>Is there evidence the provider agency provides physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities?</p> <p>42 CFR 438.206 (3) Accessibility considerations. Each IMCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.</p> <p>DMA Contract Attachment S</p> <p>A. Facility Accessibility: Contracted Network Provider facilities must be accommodating for persons with physical or mental disabilities. PIHP shall require reasonable accommodations, in accordance with 42 CFR § 438.206 contained in 42 CFR Parts 430 through 481, edition revised as of October 1, 2015, and consider the ability of Network Providers to communicate with limited English proficient enrollees in their preferred language and the ability of Network Providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Enrollees with physical or mental disabilities.</p>	<p style="text-align: center;">REVIEW GUIDELINES:</p> <p>Sample Size: N/A</p> <p>Evidence: Facility Accessibility: Contracted provider facilities must be accommodating for enrollees with physical disabilities. Agency must be observed for handicapped parking and entrance ramps; wheelchair accommodating door widths; and bathrooms equipped with handicapped railing. If the office is located in a building that is not wheelchair accessible, the provider accommodates for the accessibility needs of the enrollee in their care by making arrangements for the enrollee to be seen in an alternative location where privacy is assured, or if a provider with fewer than fifteen (15) employees finds that there is no method of complying with accessibility requirements other than making a significant alteration in its existing facilities the provider may, as an alternative, refer the enrollee to other providers of those services that are accessible. The provider assists the individual in choosing another provider who can accommodate their accessibility needs.</p> <p>Exterior and Interior Photographs must be provided that adequately demonstrate facility accessibility (refer to above).</p> <p>In the event that the review is on site the reviewer should complete, via observation, and no photographs would be required by the provider.</p> <p>Review the agency's office policy and procedure manual specific to facility accessibility, referral to other providers if needs of an individual cannot be accommodated, communications with limited English proficient enrollees, and culturally competent communications.</p> <p>Applies to the following services:</p> <p>Enhanced:</p> <p>Diagnostic Assessment, PSR, Day Treatment, Partial Hospitalization, FBC, SA IOP, SACOT, SA Non-Medical Community Residential Treatment, SA Medically Monitored Community Residential Treatment, Ambulatory Detox, Non-Hospital Detox, Medically Supervised Detox, Outpatient Opioid, Residential Services (I, II, III, IV) PRTF and Therapeutic Foster Care (Child Placing Agency)</p> <p>Innovations:</p> <p>Out-of-Home Crisis Supports; Day Supports, Residential Supports and Respite (Facility Only)</p> <p>DMH/DD/SAS State-Funded Enhanced MH/SA Services – refer to service definitions for specifics. Existing State-Funded DMH/DD/SAS Services – refer to service definitions for specifics</p>	POC



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<p>10. When required by Clinical Coverage Policy or State-funded service definitions, and as authorized by the consumer, there is documentation that coordination of care is occurring between the providers involved with the individual.</p> <p>Refer to the pertinent DMA Clinical Coverage Policy or State-Funded service definition.</p>	<p>Sample is the same 30 service events as Question 1.</p> <p>Evidence: The agency must demonstrate that coordination with other providers, organizations, and natural supports, as required by the service definition, is occurring for each client in the sample.</p> <p>Coordination of care requirements will vary by service definition, and documentation formats will vary by agency, but must be written. Common requirements include, but are not limited to: case management; coordination with medical, psychiatric, or other providers; coordination in crisis or discharge planning; participation in child and family teams. If an individual refuses to allow the agency to contact other providers or natural supports, the agency must provide documentation of the refusal.</p> <p>Clinical Coverage Policies 8A, 8A-1, and 8A-2: Coordination of care expectations vary by service definition. Documented activities should be based on service definition requirements and individualized according to the PCP. All service definitions except Diagnostic Assessment, Partial Hospitalization, and Detoxification services contain some description of expected coordination activities. For claims for these 3 services, this item should be marked N/A. Mobile Crisis Management requires coordination through crisis planning at discharge. Professional Treatment Services in Facility-Based Crisis Program and Substance Abuse Medically Monitored Community Residential Treatment require linkage to the community at discharge.</p> <p>DMH/DD/SAS State-Funded Enhanced MH/SA Service Definitions - same guidance as above.</p> <p>Existing State-Funded DMH/DD/SA Service Definitions - same guidance as above.</p> <p>Clinical Coverage Policy 8C: Reference - Section - 7.2.2</p> <p>Clinical Coverage Policy 8P: For claims for Innovations services this item should be marked N/A.</p> <p>Scoring: For each service which requires care coordination, the agency must provide documentation, examples include but are not limited to: authorization on file, service note, correspondence, documents from other providers, that demonstrates coordination with another agency, organization, or natural support, as described by the service definition, and individualized to the consumer in order for this review item to be scored as met.</p> <p>In reviewing this item, reasonable consideration must be given to clearly documented efforts by the provider to ensure linkage and coordination through various mechanisms, e.g. documented phone calls, emails, correspondence, but have resulted in no response. This item would be scored as MET.</p>	<p>POC</p>	