Routine Review Tools for LIPs

Alison Rieber, LCSW
Provider Network Evaluator Supervisor

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Routine Monitoring

• LME/MCOs have been assigned oversight responsibility to assure that provision of publicly-funded Mental Health, Intellectual/Developmental Disabilities and Substance Abuse services meet standards and requirements set forth in applicable laws, regulations, implementation updates, bulletins, manuals, Clinical Coverage Policies, contracts, the 1915 b/c Waiver and the NC State Plan for Medical Assistance.

• Monitoring follows the process developed by the North Carolina DHHS- LME/MCO-Provider Collaboration Workgroup. This group consists of representatives from state government, LME-MCOs and provider organizations.
Routine Monitoring

• The DHHS-LME/MCO-Provider workgroup collaboratively developed the review questions and specific guidelines used to monitor the questions. The goal was to create a fair, transparent process with inter-rater consistency in interpretation and scoring across the state.

• More information about the monitoring process including copies of the monitoring tools may be found on the Division of MH/DD/SAS provider monitoring webpage at www.ncdhhs.gov/mhddsas/providers/providermonitoring/

• The monitoring tools exist as Excel workbooks. The guidelines are found within the workbook as Adobe Acrobat documents.
Routine Monitoring

• Solo and group practices, as well as agencies who provide only outpatient behavioral health services are monitored using the DHHS Review Tool for Routine Monitoring of Licensed Independent Practitioners.

• This Review Tool is an Excel workbook which includes an LIP Review Tool and a Post-Payment Review. Providers are required to demonstrate compliance with the standards and regulations measured by each tool, although the tools may be used separately or together when monitoring.

  • It is Alliance practice to use both tools when monitoring providers whose main office is located within the Alliance catchment area.
Routine Monitoring Process
What to Expect

- Routine Monitoring occurs at a minimum of every two years.
  - LME/MCOs are contractually required by DMA to conduct post-payment reviews at least every 2 years.

- Providers will receive a written routine monitoring announcement 3 – 4 weeks in advance. In addition, the lead evaluator will attempt to reach you by phone to arrange the monitoring.

- The lead evaluator is available to provide technical assistance and to answer questions about the monitoring process and expectations. Technical assistance includes identifying resources and explaining requirements and expectations. Evaluators are not able to pre-monitor any material or documentation.
Routine Monitoring Process

What to Expect

• The monitoring tools are based on paid claim dates of service. Routine monitoring uses a random sample of claims from a time period 6 months prior to the review moving forward 90 days.
  • Sample size for group practices and agencies is 30 claims
  • Sample size for solo practices is 10 claims

• Monitoring is conducted according to the questions and the guidelines in the monitoring tools. Each question is reviewed for the consumer and claim date of service obtained in the random sample.

• Items are scored as met or not met according to the relevant requirement and as described in the guidelines.
Routine Monitoring Process
What to Expect

• During the monitoring:

  • The evaluators will conduct an entrance conference during which they will introduce themselves and discuss the purpose of the review and expected time frames.

  • Evaluators may ask questions about documentation or inform the provider about missing documentation throughout the review. Providers have until the scheduled end of the review to provide any missing documentation.

  • The evaluators will conduct an exit conference at the end of the monitoring during which they will outline identified areas of non-compliance. Providers are encouraged to ask questions or raise concerns. Evaluation results are not complete at this stage as evaluators may need to research specific findings, questions raised by providers, as well as compiling the findings of each evaluator.
Routine Monitoring Process
What to Expect

• Following the monitoring:
  
  • Providers should receive results within 15 calendar days.

  • Results will include a copy of the monitoring tool with specific comments and citations for any items cited as not met.

  • If any systemic areas of non-compliance were identified, the provider will be issued a statement of deficiencies and be required to complete a Plan of Correction.
    
    • Alliance follows the state’s Plan of Correction Policy located at http://www.ncdhhs.gov/mhddsas/providers/POC/poc-policy.pdf

  • If any claims are found to be out of compliance on the Post-payment review tool, Alliance will submit an Improper Payment Chart and issue a recoupment for those claims.
Provider Preparation for Monitoring

• Providers are strongly encouraged to prepare for monitoring by
  • Reviewing the guidelines, tool and underlying regulations and policies
  • Conducting internal audits to determine their compliance with the requirements.

• The guidelines are notated with the citations for the regulation, rule or policy requirement. Common sources for requirements include:
  • North Carolina General Statutes Chapter 122C
  • The North Carolina Administrative code 10A NCAC Chapter 27
  • HIPAA 45 CFR 164
  • Clinical Coverage Policy 8C
  • Records and Documentation Manual APSM 45-2
LIP Review Tool

- This tool consists of 3 sections
  - Rights Notification
  - Care Coordination/Service Availability
  - Storage of Records
- In the DHHS Review Tool excel workbook, the spreadsheet behind the LIP Review Tool is the Records Release Checklist. This checklist is part of the LIP Review Tool. It details each element required in the release of information. The evaluators score each release using the checklist and the results from this page automatically score question 5 on the LIP Review Tool.
Rights Notification

- It is important that rights information provided to the individual/legally responsible person
  - Be provided in writing
  - Specifically include all of the elements cited in the tool as detailed in the guidelines.
  - Is documented through the dated signature of the individual/legally responsible person where required by regulation and as noted in the guidelines.
Item 1: There is evidence that the individual or LRP has been informed of their rights. 10A NCAC 27D .0201

Notification must include at a minimum the following 3 elements:

- How to contact Disability Rights North Carolina
- Rules to be followed and possible penalties.
- How to obtain a copy of one’s treatment/service plan

- Information must be given within 3 visits (72 hrs. for residential services)

- All areas above must be met to rate this item “Met”
Item 2: The individual has been informed of the right to consent to or to refuse treatment.  G.S. 122C-57(d); 10A NCAC 27D .0303 (c)

• Notification must include at a minimum the following 2 elements
  
  • The right to refuse treatment as described in the statute without threat or termination of services except as outlined in the statute
  
  • That consent for treatment may be withdrawn at any time.

• Consents for treatment must be signed by the individual/legally responsible person
Item 3: The individual is informed of right to treatment, including access to medical care and habilitation, regardless of age or degree of disability. G.S. 122C-51

- Notification must include at minimum the following two elements:
  - The right to treatment, including access to medical care and habilitation regardless of age or degree of mh/dd/sa disability.
  - The right to an individualized treatment or habilitation plan
Item 4: The individual has been notified that release/disclosure of information may only occur with a consent unless it is an emergency or in 45 CFR 164.512 of HIPAA

- Release/disclosure of information is regulated by numerous federal and state laws and regulations which are explicitly cited in the guidelines for this question.

- Notification must be in writing and include at a minimum
  - That confidential information may not be released without written consent except in emergency or as provided for in G. S. 122C-52 through G.S. 122C-56. Notification of exceptions should explicitly include:
    - In case of emergency treatment
    - Request from a funding source
    - Or an audit
  - That provision of services is not contingent upon consent and of the need for the release. Consent is voluntary.
  - That confidential information may not be disclosed without written consent when federal regulations prohibit that release.
Rights Notification
Releases of Information

• It is important that Releases of Information contain all required elements.
  
  • Check Release of Information forms to ensure that all required elements are present on the form.
    
    • Ensure that individuals/LRPs have the right to specifically consent to or decline release of HIV or Substance Abuse information.
  
  • Audit completed Releases of Information to ensure that the forms are fully completed addressing each required element.
    
    • Ensure that forms are individualized, specific and only allow for release of minimum necessary information as required by 45 CFR 164.502(b), 164.514(d).
Item 5: Authorizations to release information are specific to include [the items below].

10A NCAC 26B .0202

- The service recipient’s name
- The name of the facility releasing the information
- The name of the individual(s), agency(ies) to whom the information is being released
- The information to be released
- The purpose of the release
- The length of time the consent is valid (which may not exceed 365 days)
- A statement that consent may be revoked at any time except to the extent that action has been taken
- The signature of the individual or legally responsible person
- Date the consent is signed
- A statement regarding the protection of substance abuse information per the requirements of 42CFR Part 2
- A statement regarding the protection of HIV/AIDs information under G. S. 130A - 143
Item 6: As required by Clinical Coverage Policy and as authorized by the consumer, there is documentation that coordination of care is occurring between providers involved with the individual. Clinical Coverage Policy 8C - 7.2.2

- Clinical Coverage Policy 8C Section 7.2.2 describes a number of activities which constitute care coordination of outpatient behavioral health services.
- It is expected that care coordination will be individualized to the person receiving services.
- The provider must maintain written documentation that such activities have occurred, unless care coordination is specifically refused by the individual/LRP in which case the refusal should be documented.
  - There is no required format for documentation of care coordination activities, but the provider must be able to provide documentation to the evaluators.
Item 6: As required by Clinical Coverage Policy and as authorized by the consumer, there is documentation that coordination of care is occurring between providers involved with the individual. Clinical Coverage Policy 8C - 7.2.2

- The provider shall coordinate and document the coordination of care activities, including the following:
  
  a. Written progress or summary reports;
  
  b. Telephone communication;
  
  c. Treatment planning processes. An individualized plan of care, service plan, treatment plan, or Person Centered Plan (PCP) consistent with and supportive of the service provided and within professional standards of practice, is required within 15 business days of the first face-to-face beneficiary contact. When the beneficiary is receiving multiple behavioral health services in addition to the services in this policy, a PCP must be developed with the beneficiary, and outpatient behavioral health services are to be incorporated into the beneficiary’s PCP;
  
  d. Coordination of care with the beneficiary’s CCNC/CA care manager (if applicable) and primary care or CCNC/CA physician;
  
  e. Coordination of care with the physician who is providing ‘incident to’ oversight; and
  
  f. Coordination of care with PIPH (not applicable for NCHC beneficiaries); and
  
  g. Other activities jointly determined by the referring provider and the behavioral health provider to be necessary for the continuity of care.

- Note: For coordination of care pertaining to billing, see Attachment A of Clinical Coverage Policy 8C. Coordination of care activities are included in the administrative costs for this service and are therefore not billable.
Item 7: The LIP provides or has a written agreement with another entity for access to 24-hour coverage for behavioral health crisis services. Clinical Coverage Policy 8C - 7.4

- Enrolled providers shall provide, or have a written agreement with another entity, for access to 24-hour coverage for behavioral health emergency services. Enrolled providers shall arrange for coverage in the event that he or she is not available to respond to a beneficiary in crisis.

- Documentation of 24 hour crisis coverage will vary, but must include
  - Documentation that the individual/LRP has been given specific information about how to access services during a crisis
  - Documentation that the practitioner is providing 24 hour coverage or has a written agreement with another entity to provide this coverage
    - Simply referring individuals to Alliance, a facility based crisis service, mobile support or hospital is insufficient. The practitioner is required to provide coverage and refer individuals to additional crisis services following their clinical assessment.

- The LME/MCO monitoring team may choose to test the crisis number at their discretion.
Item 8: The LIP complies with HIPAA/Confidentiality requirements by ensuring privacy and secure storage of records. APSM 45-2 Chapter 2-7 through 2-9, 45 CFR Part 164

- 45 CFR § 164.530(c) (c)(1) Standard: Safeguards

- A covered entity must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information.

- (2)(i) Implementation specification: Safeguards

- A covered entity must reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the standards, implementation specifications or other requirements of this subpart.

- (ii) A covered entity must reasonably safeguard protected health information to limit incidental uses or disclosures made pursuant to an otherwise permitted or required use or disclosure.

Item 8: The LIP complies with HIPAA/Confidentiality requirements by ensuring privacy and secure storage of records. APSM 45-2 Chapter 2-7 through 2-9, 45 CFR Part 164

- Providers are expected to have a policy on the protection and storage of records to ensure that they are
  - Only accessible to authorized personnel
  - Are stored and transported securely

- Evaluators will review the physical site to ensure that records are stored securely.

- If the provider uses an Electronic Medical Record they must be able to demonstrate that it can be accessed only by authorized users.

- If PHI is stored on portable devices such as laptop computers or flash drives, those devices must be encrypted.