ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

External Protocols for
FY15 Post-Payment Review (PPR), Clinical Practice and Guidance (CPG)
Quarter 1 and 2

Scheduling of Reviews

During FY15, all DHS/DMH contracted providers will receive a Post-Payment Review (PPR) and a Clinical Practice and Guidance (CPG) review. Each type of review (PPR and CPG) is a separate review with separate reports and scores. Provider monitoring reviews will not be coordinated with BALC Certification reviews. The Collaborative Regional Liaison Supervisor is responsible for developing the confidential review schedule.. The confidential review schedule is distributed by the Collaborative Training Coordinator.

The review schedule is very tight and it is not possible to change scheduled review dates, with the exception of an emergency or unusual situation. Providers may contact the Collaborative Regional Liaison Supervisor to discuss the situation. If something comes up after the review has been scheduled that would affect the ability to conduct the review, the Collaborative Regional Liaison Supervisor needs to be notified.

Provider Notification

All reviews will continue to be announced. A claim run will be collected and organized prior to post payment reviews, for use by the review team. Providers will be notified one week prior to an impending review by the Collaborative Training Coordinator. Information regarding the date of the review, the names of reviewers and the records being reviewed will be related verbally at this time. The Collaborative Training Coordinator will gather information about the provider for the reviewers and answer provider questions. Following the phone contact, providers will receive a secure email from the Collaborative Training Coordinator containing a list of consumer names and associated RINs for the records to be reviewed.

Provider Monitoring Tools

Provider Monitoring tools and ancillary documents are located on both the IL Mental Health Collaborative for Access and Choice website and the DHS/Division of Mental Health website. Links to these websites are: www.illinoismentalhealthcollaborative.com and www.dhs.state.il.us (then search for "FY15 Provider Manual").

Post-Payment Review (PPR) Tool:
Provider clinical documentation for a sample of claims approved for payment is reviewed according to a set tool. This tool covers aspects of compliance with the IL Mental Health Medicaid Rule (59 Ill. Admin. Code pt. 132)

Medicaid CPG Tool:
The purpose of this tool is to measure 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.

Non-Medicaid CPG Tool:
The purpose of this review is to assess two aspects of services to non-Medicaid eligible individuals. DHS/DMH reimburses a limited range of services for non-Medicaid individuals. These items do not create the expectation that providers must provide services that are not reimbursed. The intention of these items is to give feedback and to recognize best practices to share across providers.

Sampling Methodology and Claim Review Period

Post Payment Review
In order to establish a sampling methodology for post-payment review (PPR) for FY15, the Collaborative was given the following guidelines from DHS/DMH:

- The sampling methodology selected must be reflective of the volume of claims each provider has submitted during the specific identified claim period rather than a flat number of claims per provider.
- The claim period will vary from provider to provider, but will begin 12 months prior to the date the claim run is developed and ends with the date the claim run is developed For providers who received a PPR in FY14, the claim period will begin 9-12 months from the last review. The claim run will only include processed and approved claims.
- The sampling methodology must be statistically sound such that findings can be used for recovery and potential extrapolation.
- HHS OIG RAT-STATS, 2007, version 2 Software will be the chosen sampling tool.

Based upon this request, the Illinois Mental Health Collaborative for Access and Choice will provide sample size calculations that are statistically valid for the defined confidence level and margin of error. The Collaborative will utilize the following sampling methodology for FY15:

1. The claim period will vary from provider to provider, but will begin 12 months prior to the date the claim run is developed and ends with the date the claim run is developed. In the event that the provider received a PPR in FY14, the review will be scheduled to occur at least 9-12 months from the date of the last review in order to ensure the largest claim sample possible.

2. A statistically sound random sample of all adjudicated claims per specified provider will be selected for post-payment review using the sample calculator within HHS OIG RAT-STATS,

2007, version 2, Software to reach a 90% confidence level with a 16% desired precision range (margin of error +/- 8%).

A. To guarantee the 16% desired precision range, an anticipated rate of occurrence of 50% will be used when calculating the number of claims to be reviewed per provider.

B. The number of claims each provider submitted during the provider's identified unique claim period (universe size) will be determined using ValueOptions' IntelligenceConnect reporting system.

C. Once the sample size has been determined using HHS OIG RAT-STATS, 2007, version 2 Software, a provider specific claim run will be developed using the ValueOptions© IntelligenceConnect reporting application.

D. Claim runs will be developed for each provider approximately two (2) weeks prior to the scheduled review by the Collaborative Training Coordinator.

Clinical Practice and Guidance (CPG) Sampling

All DHS/DMH identified contracted providers will receive a CPG review during FY15. For each review, ten Medicaid records and two non-Medicaid records will be randomly selected from the overall PPR claim run using the statistical tool, Random.org.

Notification of Results, Follow-up, Plans of Improvement

PPR Formal Notification and Follow-Up

Providers will continue to receive preliminary results at the exit conference. Providers scoring 50% and above will receive a letter from the Collaborative entitled: *Notice of Unsubstantiated Billing* within 30 days following the PPR. Note that supporting documentation is no longer allowed by 59 Ill. Admin. Code pt. 132 (7/1/14).

For providers scoring 50% and above, DHS/DMH Contract Managers are responsible for approving and monitoring the formal Plan of Improvements. Additional follow up including a return review may be enacted if a provider has a significantly low overall score. All Plans of Improvement need to be sent to the provider's DHS/DMH Contract Manager with only a courtesy copy going by mail to the Collaborative.

A formal PPR Plan of Improvement is required if the following thresholds are not met for individual items: for items 1, 5 and 6 the threshold is a score of 90%; for items 2-4 and 7-11, the threshold is a score of 80%. In addition, an overall total substantiated PPR score less than 70% would trigger an overall plan of improvement. Items A and B are quality indicators. There are no thresholds associated with Quality Indicators.

Providers should begin making indicated changes to their procedures to become compliant with requirements immediately following the exit conference.

In the event that a provider receives a total substantiated score of less than 50% a letter of *Notice of Unsubstantiated Billing* and *Notice of Suspension from Billing* (one letter) will be sent to the provider. This letter will provide instructions outlining requirements of 59 Ill. Admin. Code pt. 132 (7/1/14). An additional review will be required to ensure that corrections have been made to ensure compliance with 59 Ill. Admin. Code pt. 132 (7/1/14). This additional review may be performed on-site or by desk audit. The letter will specify how this additional review will occur. Following this additional review, if findings indicate that providers continue to remain out of compliance findings will be forwarded to the state certifying body for further action.

CPG Formal Notification and Follow-Up

Providers will be sent a Notification of Findings letter within 30 days after completion of the Clinical Practice and Guidance review. A formal CPG Plan of Improvement (POI) is required for any item that scores "below a 4.0 on the Medicaid CPG Tool. Plans of Improvement are to be submitted to DHS/DMH Regional staff with a courtesy copy to the Collaborative (Illinois Mental Health Collaborative, 400 S. Ninth Street – Suite 201, Springfield, IL 62701, Attn: Training Coordinator). Providers have the option of using their own format for the POI report including all of the specified elements or using the DHS/DMH format. Plans of Improvement need to be submitted within thirty (30) days from the date on the DHS/ DMH Clinical Practice and Guidance review letter. DHS/DMH Regional staff may request a revised plan and will monitor progress.

Policy Pertaining to Conflict of Interest

The Collaborative has a Conflict of Interest policy in place which prevents Collaborative staff from participating in the monitoring of providers for which the staff person has other vested interests or potential conflicts with the provider.

The Collaborative Regional Liaison Supervisor maintains an updated list of providers who would pose a conflict of interest situation for specific Collaborative staff. The Director of Quality Management is responsible for ensuring compliance with this policy, making any adjustments to it and is the final authority in determining whether or not a conflict of interest exists.

Policy Pertaining to Handling Problem Situations While at the Provider Site

In the event that a reviewer encounters a problem situation while at the provider site, reviewers are instructed to contact the Collaborative Regional Liaison Supervisor who will also notify DHS/DMH and the Collaborative Director of Quality Management.

Reviewers' Guidelines While On-site

Reviewers will:

1. Arrange (lead will facilitate) a meeting place and time with other team members and enter the provider site together as a group.

2. Carry identification at all times.

3. Maintain the confidentiality of all consumer health care information and provider records, including not leaving consumer or provider records unattended, and ensuring and documenting the return of all records to the provider prior to departure.

4. Document all data on Collaborative forms and/or database.

5. Ensure that handwriting is legible and written in ink when data documentation is done manually.

6. Regional Liaisons document findings on PPR worksheets that are generated through the FY15 Provider Monitoring Access Database. The Regional Liaison Supervisor is responsible for performing a quality check on these worksheets prior to the review. There is one worksheet per claim being reviewed. Regional Liaisons will record findings on every item on each worksheet (no items are to be left blank). If the item is substantiated, Regional Liaisons will write a + in the findings column for the item. If the item is unsubstantiated, the Regional Liaison will place a checkmark in the findings column for the item with comments explaining why the item is unsubstantiated. Dates of the ITP and MHA that were reviewed specific to the claim will have the date of the LPHA signature recorded on the worksheet. Reviewers are to designate whether the ITP and MHA were initial documents or update/reviews. Reviewers are to note on the worksheet any addendums related to documents that were reviewed.

7. Be responsible for ongoing quality assurance throughout the review, e.g. ensuring that data is being recorded on the most recent and correct document and that reports contain accurate information.

8. Report all mandated abuse and/or neglect allegations immediately to appropriate provider staff, which are then required to file a report with Office of Inspector General, the DCFS Hotline or Department of Aging in conjunction with the Regional Liaison. The Regional Liaison Supervisor needs to be contacted immediately, who will then immediately notify the DHS/DMH Central Office and the Director of Quality Management. If the provider refuses to file a report, the Regional Liaison is required to do so.

9. Immediately consult with the provider Executive Director or designee upon identification of any instance that poses an immediate risk to consumer safety or service delivery, including but not limited to: inadequate staff levels, closure of sites, safety concerns, or non-credentialed staff dispensing medications. Within four hours the Collaborative Regional Liaison Supervisor must be notified by the lead Regional Liaison, who will then contact DHS/DMH Central Office and the Quality Management Director.

10. Turn cell phones to mute or vibrate throughout the course of the review. All necessary phone calls must be conducted in a private area away from the review area.

11. Present a professional appearance, attire, and demeanor.

12. Ensure that the least amount of disruption to the provider and the provider's services occurs throughout the course of the review.

Entrance Conference

Upon arrival at the site:

- The Lead Regional Liaison will identify him/herself to the provider receptionist and ask to speak with the provider contact person
- The review team will conduct an entrance conference with the provider contact person, Program or Clinical Director, and other staff the provider deems important.
- During this conference the review team will utilize the designated Talking Points.

Final Day

The provider will be given, at minimum, two hours' notice in order to allow the provider time to notify staff and adjust schedules, if necessary. Review team members will take time prior to the exit conference to confer about the findings of the reviews. The lead Collaborative Regional Liaison will contact the provider's Contract Manager to inform them of any identified issues/significant findings and to invite them to the exit conference

In the event that there are significant findings, the lead reviewer should brief the designated provider contact in advance of the exit to ensure their understanding.

Reviewers will notify the provider contact of missing documents during the course of the review and ask them to locate them to ensure all needed documents were assessed during the review. In order to ensure that reviewers can complete the assessment in a timely manner, reviewers will give the provider contact a final time that documents can be submitted before the exit conference

Exit Conference

At the time designated for the Exit Conference, the lead reviewer will utilize the appropriate Exit Conference Talking Points.

- All review reports must be signed by the entire review team and the provider. The original signed reports will be returned to the Springfield Collaborative office by the lead Liaison and placed in the provider file. Leave a copy of the completed Post-Payment Summary and the PPR Billing Issues Summary along with all other applicable review reports with the provider contact person.

- Explain to the provider that a copy of the reports will be forwarded to DHS/DMH for review and that the assigned Contract Manager will be following up with the provider on any required Plans of Improvement. The Collaborative will maintain the confidentiality of the review contents.

- Return all provider materials and have the provider sign off that all provider records were returned to provider at the conclusion of the review.

- Distribute the Provider Monitoring Review Questionnaire and stamped envelope to the provider contact person. This is a survey where providers can give their feedback on the process. Envelopes will be addressed to DHS/DMH who will collect and analyze the data.

Transportation of Confidential Records

All reviewers must comply with the ValueOptions Policy: LC403 - Physical and Electronic Security of Personally Identifiable Information, revised 1/24/14.