WASATCH BEHAVIORAL HEALTH
SPECIAL SERVICE DISTRICT

Peer and Electronic Record Review – C – 3.12

Purpose:

The purpose of Wasatch Behavioral Health's (WBH) peer review program is to ensure the quality and sufficiency of medically necessary services provided to clients using a clinical record auditing process, and to report findings of improper, unacceptable, or inappropriate quality and quantity of care, documentation, coding, and billings at the client and agency level to the appropriate group for corrective action.

Definitions:

Medically Necessary: any mental health service that is necessary to diagnose, correct or ameliorate a mental illness or condition, or prevent deterioration of that mental illness or condition or development of additional health problems and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

Over-Utilization: mental health services provided in excess of what is medically necessary, and which could have been provided in a more conservative, and/or substantially less costly manner.

Under-Utilization: mental health services provided less adequately than what is required to be medically necessary, and which should have been provided in a more comprehensive, and costly manner.

Policy:

A. WBH shall establish and conduct peer reviews through its QAPI Committee's Peer Review Sub-Committee following the standards identified in the QAPI Committee's policies and procedures. The Peer Review Sub-Committee shall facilitate conducting peer reviews of open Medicaid clinical records quarterly using the following policies and procedures.

B. The Peer Review Sub-Committee shall be trained on the purpose and importance of their responsibilities, and on how to use the approved auditing instruments and auditing process indicated herein to conduct quality peer reviews.

C. The clinical record database (Junction) shall be searched electronically by the Information Technology/Information/Services Department (IT/IS), the Clinical Records Department, and the program managers using a predetermined schedule, to identify potential problem areas with documentation, adequacy of service delivery, completeness of the clinical record, timeliness of services, etc.

Procedures:

Employee Provider Peer Reviews:

1. The Peer Review Sub-committee shall consist of the Division Director ofCrisis and Intensive Services who shall act as Committee Chair and also include a representative from each Division (SUD, Clinical and Community Services and Corporate/Clinical Compliance). The Chair shall select committee members. Members shall include case managers, program managers, and supervisors from the Clinical and Community, SUD and Crisis and Intensive Services divisions. All shall be licensed or certified mental health providers, social service workers, or providers practicing under the supervision of a licensed mental health provider.
2. Peer Review Sub-committee members shall share the information learned during the meetings with the staff with whom they work. In coordination with division directors and program managers, members shall ensure each staff member reviews one client chart from a peer in their program , twice each calendar year. The committee shall meet no less than quarterly for 1hour. During each meeting, the clinical records which have been reviewed shall be reported. The identified auditing forms herein and tracking reports shall be used to review the chart audits.

3Peer Review Sub-committee members shall support program managers to ensure the auditing instruments are completed. Every PSC is expected to complete, at a minimum, a review of 2 peer charts each calendar year. Program managers will determine if additional reviews should be completed in their program. Managers will also coordinate assigning files to be reviewed for each PSC in their program**.**

Detailed instructions on this process can be found in Appendix A of this policy as well as in the shared drive under (shared.managers/Peer Audit Monitoring Tools/Mental health Monitoring Tools/Monitoring Tool Input Template). Note that aggregate data for the center and each department can be viewed at the same location in the shared drive.

4. The Peer Review Sub-committee chair and assigned CTA shall track and maintainthe completed audit instruments for record retention purposes. Data is available at the shared drive location indicated in item #3 of this section.
5. The Peer Review Sub-committee Chair shall report any violation concerns to the WBH Corporate Compliance Officer *(See policy C-3.13 WBH Fraud and Abuse).*
6. Quarterly, the Peer Review Sub-committee Chair or designee shall provide a written report to the QAPI Committee of his/her Committee's activities and findings for the preceding quarter.

Medical Staff Peer Reviews:

1. Medical staff prescribers shall conduct quarterly self-audits of open client clinical records using the identified auditing instrument *(A-3.04 Medical Peer Review Audit form- See sample attachment).*
2. The prescribers shall evaluate only the prescriber notes from individual client visits, not the entire clinical record. Prescribers shall not review their own clinical records.
3. Prescribers shall submit the original auditing instrument to the Medical Administrative Program Manager for review. The manager shall address any errors and make necessary changes.
4. All completed audit instruments shall be tracked and maintained by the Medical Administrative Program Manager or her/his designee.

Outside Provider Auditing Procedure:

1. All WBH clients' currently in services with contracted outside providers shall have their clinical record and billing documentation audited by the Outside Provider Contract Program Manager (program manager) or his/her designee annually.

2. The program manager shall audit five percent (5%) of open each client clinical record that is open and assigned to each provider. When the provider serves more than one client, the program manager shall audit a maximum of five clinical records.
3. The program manager shall use the identified audit instrument Peer Review Audit Instrument for Outside Providers *(A – 3.03 Peer Review Audit Instrument for Outside Providers form - See sample attachment)* while conducting the audits.
4. Specialized audits may be initiated based on client complaints, suspicious billing practices, etc., or from other information coming to the attention of the Executive Committee and/or the program manager.
5. The program manager shall notify the outside provider orally and in writing of any negative audit findings. The outside provider shall have 90 days from the date of notification to correct errors.
6. The program manager shall ensure all negative audit finding are corrected.
7. A copy of the completed audit form shall be maintained by the program manager and shall not be filed in clinical records.
8. The auditing instrument shall be periodically reviewed and updated as needed and correlate with the instrument used for WBH internal audits.
9. The program manager shall report issues of significant concern or identified billing errors to the Peer Review Committee Chair.
10. The program manger shall report the audits conducted and negative audit findings to the Peer Review Committee Chair who shall include the program manager's information and findings in his/her quarterly QAPI report.

Peer Review Committee Training:

The committee members shall receive training in the various aspects of a quality peer review audit. Training may include items such as the following depending on training needs:

1. The record of service delivery meets all relevant data and time requirements necessary for service validation.
2. The record of service delivery is consistent and congruent across related data elements, and the substance of the record reflects appropriate medical necessity, and adequate quality of professional mental health care service.

3. The person providing the various treatment services must be properly credentialed to provide the service delivered.
4. The services identified in the recovery plan are being provided and all services provided are included in the recovery plan.
5. Utah State Substance and Mental Health Best Practice Guidelines are included in treatment plans and progress notes where Guidelines exist.
6. Progress notes shall reflect client progress towards identifying objectives and goals.
7. Any additional items requested by the Utah Office of Substance Abuse and Mental Health to be included in the audit process and audit tool.

Electronic Records Review:

Reports on all active clients shall be generated from WBH"s electronic record database (Junction) and distributed to the two division directors for review. The division directors shall circulate the reports to the appropriate program managers who shall ensure each listed item is reviewed for completeness, accuracy and appropriateness of service. The program manager shall ensure the appropriate staff person makes any needed corrections.

Electronic Record Audits:

The clinical record audit is coordinated through the IT/IS department. The IT/IS staff member assigned shall conduct a review of all clinical notes to detect any errors including cost centers and locations, excessive duration and service codes. If errors are found, the staff member shall:

1. Void the service(s) to prevent incorrect billing transaction.
2. Send an email to the division director, program manager and clinician responsible for the note informing them of the error(s) that the clinician will need to review and correct. Once the error(s) have been corrected, the clinician shall electronically sign and save the note. The Division Director shall review the note to ensure that the error(s) have been corrected.

Client Court Commitment Review Sub-Committee:

1. The Client Court Commitment Review Sub-Committee shall be chaired by a master level clinician and designated by the Adult Crisis Services Program Manager.

Committee members shall include case managers and therapy providers. The committee shall convene monthly to review the necessity of continuing civil court commitments on clients scheduled the following month for a desk court review, or a court appearance.

2. Client progress shall be reviewed regarding their current services, level of participation, current functioning, and current needs using the Utah State statute criteria for continuing commitment.
3. A note documenting the review committee's findings for needing, or not needing, continuing court commitment shall be completed and placed in the client's record.
4. The client's case manager shall prepare and submit a note to the court giving WBH's findings and recommendations based on the review committee's decision.
5. The committee shall conduct a review of clients on indeterminate court commitment every six-months at a minimum and more frequently when requested by the client. When a client requests a review, the client's name shall be placed on the court's docket. In the month prior to the hearing, the committee shall review the client's ability to receive or discontinue treatment absent court ordered treatment. Should the committee decide court ordered treatment continues to be necessary, it shall make their recommendation known to the court. Should it decide involuntary treatment is no longer necessary; the committee shall notify the court.
6. The committee shall honor a treatment team member's request for a review of their client's need for continued court commitment when it is believed the client no longer meets the required criteria. When the committee agrees with the client's treatment team, paperwork shall be filed notifying the court the commitment is no longer necessary.

Related Policies:

C - 3.07 QAPI

C - 3.13 Fraud and Abuse

A - 1.10 Selection and Retention

Related Forms:

A - 3.03 Peer Review Audit Instrument for Outside Providers

A - 3.04 Medical Peer Review Audit

Right to Change and/or Terminate Policy:

Reasonable efforts will be made to keep employees informed of any changes in the policy; however, WBH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

Appendix A – peer monitoring tool instructions & template

1. Click on File, and then "Save As." Then, save this document in your files with your name, and the name of the clinician whose chart you are auditing in the file name.
Hint: If you have two computer screens, pull up the client's chart on one screen and this document on the other screen.
2. Click on the "Monitoring Tool" tab at the bottom of the screen.
3. Fill in the fields in the box at the top of the screen with the employee ID of the clinician you are reviewing, your employee ID, the name and Junction ID of the client whose chart you are reviewing, the date you are performing the review, the age of the client, whether or not the client has Medicaid, and the three digit code for your cost center.
Hint: If you don't know the employee ID for the clinician whose chart you are reviewing, it can be found in the leftmost column of the WBH Directory, found in your Junction Portal. If you are unsure of your cost center, consult with your program manager.
4. Review the chart and place an "X" in either the "Yes," "No," or "NA" box for each question.
5. Fill out the three narrative boxes at the bottom of the form.
Hint: It can be useful to fill these out as you go so that if you are interrupted part way through the review, you don't forget important information.
6. Once you have completed the review, save it and email it to the PSC whose chart was reviewed, as well as your program manager. If any critical items were not addressed in the chart (this can be determined by checking to see if any numbers are listed above the "Clinician and/or Chart Strengths" box near the bottom of the form), mention this in the body of your email so that the clinician can know to make the corrections.
Congratulations!: If you are the clinician completing the review, you are done!
7. If you are the clinician whose chart is being reviewed, look over the review form and consider the feedback that was provided.
8. If any Critical Items were listed, please correct those items. Once they are corrected, add the date to the field labeled "Date Corrected," save the document, and email it to your manager with a message indicating that the corrections have been completed.
Congratulations!: If you are the clinician whose chart was audited, you are done!
9. If you are the program manager, review the monitoring tool for completeness and for any training needs, and then email the tool to Tammy Haun, who will enter it into the database.

10. After the tool has been entered into the database, this tool and aggregate date for the center and your department can be viewed by accessing the "Monitoring Tool Tracking Sheet" found at the following location on the shared drive: Shared.managers > Peer Audit Monitoring Tools > Mental Health Monitoring Tool.

Children/Youth/Adult Mental Health Peer Review Monitoring Tool

(As indicated by the Utah Office of Substance Abuse and Mental Health and Medicaid guidelines)

Clinician Being Reviewed:	Date of Review:
Reviewers:	Client Age:
Client Name:	Medicaid: Yes / No
Client ID #:	Cost Center:

Yes	No	N/A	#	ASSESSMENT,SAFETY, YOQ
			1	Is there a clear explanation of the presenting problem?
			2	Is there focus and documentation of the client's immediate needs?
			3	Evidence client was given options and had choice regarding treatment plan?
			4	CSSRS administered in last year if there is was an indicated need?
			5	Safety Plan present with evidence of reviews (if there was an indicated need)?
			6	Follow up Care Plan after any hospitalization or suicide attempt?
			7	Trauma History is evaluated
			8	Treatment history documented with collateral information noted in assessment (if appropriate)
			9	Relevant involvement with outside agencies (court, DCFS, etc.) is included
			10	Client strengths are included
			11	SED/SPMI is confirmed
			12	OQ/YOQ Administered
			13	OQ/YOQ documented as an intervention (discussed with client)
			14	Culture is considered
			15	Ongoing assessment as it relates to treatment is addressed
			16	Level of care recommendation is justified by the assessment and least restrictive level of care is used
				DIAGNOSIS
			17	DSM/ICD is present
			18	Diagnosis is updated as appropriate
			19	Assessment and diagnostic formulation supports listed diagnosis
				RECOVERY/TREATMENT PLAN
			20	Plan is individualized and recovery focused
			21	Client focus and voice is evident. No jargon. Objectives in client's words. Client aspirations clear. Objectives are attainable.
			22	Barriers to treatment are addressed
			23	Treatment plan incorporates client's strengths in addressing identified problems (not just a list of strengths)
			24	SMART Objectives are used
			25	Comorbid Conditions considered (MH/SUD/ID/DD/Physical)
			26	A treatment plan with at least one goal is present in the client's chart prior to services being provided
			27	The treatment plan is culturally appropriate, cultural issues are addressed
				TREATMENT/PROGRESS NOTES
			28	Treatment is based on medical necessity
			29	Services are congruent with level of care
			30	Progress Notes document progress in treatment toward the objectives/goals
			31	Psychoeducation on illness/treatment documented in progress note
			32	Y/OQ administered monthly and incorporated into clinical process
			33	Safety needs are immediately addressed – CSSRS completed as indicated
			34	Safety plan is present when indicated clinically (in notes or assessment), or by CSSRS
			35	Outreach for missed, no show appointments
			36	Evidence of coordination with providers
			37	Evidence of coordination at transitions
			38	Documentation of mandatory reporting (abuse, neglect, exploitation) when present
			39	Discharge and continued care planning is ongoing (begins upon admission and includes discussion about when treatment will be complete).
				HOLISTIC APPROACH
			40	Screened/Seen for medication management
			41	PCP/GP identified or link offered

			42	Weight/Diabetes screened if significant
			43	Tobacco Use (in assessment), if yes, Cessation classes offered
			44	Education on social determinants of health
Yes	No	N/A	#	
			45	Case management is appropriately used to promote gains in treatment
			46	Supported Employment
			47	Inclusion of Peer Support Services in treatment when appropriate
				DISCHARGE PLANNING-for discharged clients only
			48	Discharge summary gives fair account of client's participation in and response to treatment
			49	Reason for discharge is documented
			50	Discharge documentation includes a plan established with the client and clinician for any future/continuing care

CRITICAL ITEMS - Require immediate correction and/or training (gray lines): Date Corrected:_____

#1 #5 #6 #24 #28 #30 #32 #33 #34 #45 #47

CLINICIAN AND/OR CHART STRENGTHS:

AREAS NEEDING IMPROVEMENT:

REVEIWER'S NOTES:

SCORING:

# of YES: _____

# of NO: _____

# of N/A: _____

# of YES divided by # of (YES + NO) = _____%

Signatures: _____

Supervisor: _____

SUD Peer Review Monitoring Tool

(As indicated by the Utah Office of Substance Abuse and Mental Health and Medicaid guidelines)

Clinician Being Reviewed:	Date of Review:
Reviewers:	Client Age:
Client Name:	Medicaid: Yes / No
Client ID #:	Cost Center:

Yes	No	N/A	#	
				CONFIDENTIALITY
			1	Consent form found in file (only required if information released) is complete, has statement that consent is subject to revocation, is signed and has complete information
			2	*Signature of patient and guardian if minor and date signed* *
			3	Acknowledgement of receipt of Privacy statement present, signed, and witnessed
				ENGAGEMENT SESSION AND ASSESSMENT OF SERVICE LEVEL
			4	Engagement session identifies client goals and identifies initial diagnosis.
			5	Engagement session includes statement of client's presenting problem and
			6	Identification and documentation of acute psychosis, intoxication/withdrawal relevant to presenting problem.
			7	Identification and documentation of biomedical conditions and complications relevant to presenting problem
			8	Identification and documentation of Emotional, Behavioral, Cognitive Conditions and or Complications relevant to client's current situation and presenting problem. (*include learning disabilities)**
			9	Identification, evaluation and documentation of readiness to change relevant to presenting problem
			10	Identification and documentation of Relapse, or Continued Problem Potential relevant to presenting problem
			11	Identification and documentation of client's Recovery Environment relative to presenting problem
			12	Identification of Recovery Support services needed relevant to presenting problem
			13	Engagement session summary includes recommendations for level of care and intensity of services needed.
				ONGOING ASSESSMENT
			14	Assessment Dimensions are current and are updated as new information is received, new goals are identified and client progresses
			15	Assessment process is ongoing and changes to assessment information are reflected throughout record
			16	Level of care and intensity of serves are supported by ongoing assessment information, or difference is clinically justified
				RECOVERY/TREATMENT PLAN
			17	Evidence of Client/Patient participation in development of Plan.
			18	The plan is individualized and based on the client's goals and other needs agreed on by the client
			19	Objectives are measurable, achievable within a specified time frame and reflect *developmentally** appropriate activities that support progress towards achievement of client goals
			20	Documentation of client's status is reflected throughout the client record, reflecting changes in types, schedule, duration and frequency of therapeutic interventions to facilitate client progress as well as changes in client objectives and goals
			21	Recovery Plan is current
			22	*Evidence of family involvement in treatment**
				CO-OCCURING TREATMENT
			23	Co-occurring mental health and physical health issues identified during assessment process
			24	If identified, Co-occurring diagnosis present
			25	If identified, evidence that it was discussed, and if agreed upon, addressed in recovery plan through direct services or referral for services
			26	Progress on Co-occurring issue and/or follow through on referrals are documented in record
				PROGRESS NOTES
			27	Every service contact documented
			28	Clinical service notes include the date, duration and type of intervention.
			29	Progress notes are used to document progress or lack of progress on client's goals and objectives and reflect behavioral changes as well as changes in attitudes and beliefs
			30	Progress reports and letters submitted as required and are individualized to reflect client progress
			31	Recovery support services are documented to the extent required for clinical continuity and in order to meet financial requirements
				GENDER AND CULTURAL SPECIFICITY
			32	Record reflects cultural and gender specificity in treatment
				CONTINUING RECOVERY RECOMMENDATIONS

			33	Recommendations for ongoing services include the extent to which established goals and objectives were achieved, what ongoing services are recommended, and a description of the client's recovery support plan.
			34	Signature and title of an appropriately licensed professional
Yes	No	N/A	#	
			35	Referrals and follow-up care provided (preferred).
				**Italics indicate adolescent requirements*

CRITICAL ITEMS - Require immediate correction and/or training (gray lines): Date Corrected:_____

CLINICIAN AND/OR CHART STRENGTHS:

AREAS NEEDING IMPROVEMENT:

REVEIWER'S NOTES:

SCORING:

# of YES: _____

# of NO: _____

# of N/A: _____

# of YES divided by # of (YES + NO) = _____%

Signatures: _____

Supervisor: _____