WASATCH MENTAL HEALTH SERVICES
SPECIAL SERVICE DISTRICT

Peer and Electronic Record Review – C – 3.12

Purpose:

The purpose of Wasatch Mental Health's (WMH) 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, codings, 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. WMH 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 conduct 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 instrument (*A - # 3.02 Peer Review Audit form – See sample attachment)* 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 of Child and Family Services who shall act as Committee Chair. The Chair shall select committee members. Members shall include case managers, program mangers, and supervisors of both youth and adult service divisions. All shall be licensed or certified mental health providers, or providers practicing under the supervision of a licensed mental health provider.
2. Peer Review Sub-committee members shall select any open, previously unaudited, client clinical record from their respective departments to be reviewed by another peer reviewer from the committee. The committee shall meet no less than quarterly for 1.5 hours. During each meeting, 8 to 12 clinical records, center-wide, shall be reviewed, using the identified auditing instrument *(A - # 3.02 Peer Review Audit form – see sample attachment).*
3. Peer Review Sub-committee members shall complete the auditing instrument (within two working days of the meeting and submit the original to the Peer Review Sub-committee Chair. When an error has been found and correction is needed, the reviewer shall also forward a copy to the applicable program manager. After reviewing the audit instrument findings for useful information on improving his/her department's clinical operations, the program manager shall forward the audit form to the client's Primary Service Coordinator (PSC) for error correction, etc. The PSC shall return the corrected audit instrument within 10 working days to his/her program manager. The program manager will review the PSC's corrections for completeness and within two working days return the instrument to the Peer Review Sub-committee Chair. The Sub-committee Chair shall review the audit instruments for systemic or agency issues and report any system wide issues to the QAPI Committee.
4. The Peer Review Sub-committee Chair shall track and maintain the completed audit instruments for record retention purposes.
5. The Peer Review Sub-committee Chair shall report any violation concerns to the WMH Corporate Compliance Officer *(See policy C-3.13 WMH Fraud and Abuse).*
6. Quarterly, the Peer Review Sub-committee Chair 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 *(# 3.04 Medical Peer Review Audit form).*
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 Director for review. The Medical Director shall address any errors and make necessary changes.

4. All completed audit instruments shall tracked and maintained by the Medical Administrative Program Manger or her/his designee.

Outside Provider Auditing Procedure:

1. All WMH 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 manger.
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 WMH 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.

Electronic Records Review:

Reports on all active clients shall be generated from WMH"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 Medical Administrative 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 WMH'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

Right to Change and/or Terminate Policy:

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

AGENDA
PEER REVIEW COMMITTEE MEETING

Date:

Time:

Present:

1. Purpose/explanation—Unit Manager
2. Case discussion—Everyone
   - A. Assessment
   - B. Treatment strategies
   - C. Quality of care issues
   - D. Staff feelings or concerns
   - E. Legal implications
3. Action Plans
4. Program adjustments or recommendations
5. Supportive services to the family
6. Other business

Wasatch Mental Health Clinical Record Audit Instrument A - 3.02

Client Name:	Medicaid	circle one		Client ID #:
Clinician:	Yes		No	Auditor:

I. Clinical Assessment	Y	N	n/a
1. Is presenting problem in client's/guardian's own words?			
2. Has psycho/social history been completed?			
3. Are any medical/health concerns identified/documented?			
4. Are previous solutions documented?			
5. Has substance abuse screen been completed?			
6. Has mental status been assessed?			
7. Has risk assessment been completed?			
8. Has treatment formulation been completed?			
9. Does tx formulation include the client's strengths?			
10. Is diagnoses supported by summary observations?			
11. Has SPMI/SED section been reviewed in a timely manner?			
12. Is the diagnostic section complete on all five axes?			
13. Do services indicated fit the clinical picture?			
14. Is there evidence of medical necessity?			
15. Is a crisis/safety plan done?(if warranted)			
16. Have cultural issues been addressed?			

II. Treatment Plan	Y	N	n/a
1. Does the tx plan address the current problem?			
2. Are the tx plan objectives measurable?			
3. Are the services ordered justified by the assessment?			
4. Is the tx plan complete and correct?			
5. Does the tx plan list all of the modalities utilized?			
6. Are all modalities listed on the tx plan being utilized?			
7. Is the tx plan signed and with credentials?			
8. Assessment of Over/Under Utilization of Services			
a. Amount, duration, and scope of services seen adequate.			
b. Amount, duration, and scope of services seen excessive.			
c. Amount, duration, and scope of services seem marginal.			
d. Amount, duration, and scope of services seem inadequate.			
9. Was the client over prescribed medications?			

III. Clinical Progress Notes	Y	N	n/a
1. Do notes specify progress toward goals and objectives?			
2. Do notes adequately document the service?			
3. Has the client been seen in the past 90 days?			
4. Do the notes justify continued treatment?			
5. Do goals on the progress notes meet goals on the tx plan?			
6. Does the bill code match the note content?			

IV. Case Management Services	Y	N	n/a
1. Are CM services prescribed in the tx plan?			
2. Are CM services being provided?			
3. Has the CM needs assessment been completed?			
4. Is service plan complete, current and signed w/credentials?			
5. Do service notes document progress toward objectives?			

V. Skills Development Services	Y	N	n/a
1. Are SD services prescribed in the tx plan?			
2. Are SD services being provided?			
3. Does the tx plan contain specific service objectives?			
4. Are specific skill development areas identified?			
5. Are group SDS documents by weekly or monthly summary?			
6. Do the skills notes show progress toward goals on tx plan?			

VI. Therapeutic Behavioral Services	Y	N	n/a
1. Is Behavior Management prescribed in the tx plan?			
2. Is Behavior Management being provided?			
3. Does the tx plan contain specific service objectives?			
4. Do the service notes document progress toward objectives?			

VII. Medical Services	Y	N	n/a
1. Do service notes document progress toward objectives?			
2. Does the record contain a current list of medications?			
3. Does the record contain a nursing assessment? (if required)			
4. Has the client been seen in the last 180 days?			

Please comment on any areas answered 'No' by noting section and question number, (area III - 2)

Please comment regarding Over/Under Utilization of Services:

Quality Improvement Recommendations:

Auditor Signature: **Date:**

Date corrected and by whom (please print):

Date corrected and by whom (please print):

Date corrected and by whom (please print):

Date corrected and by whom (please print):

Please Note On The Back Of This Form How You Fixed The Problem

WMH OUTSIDE CONTRACT CLINICAL RECORD AUDIT INSTRUMENT A-3.03	
Client Name:	WMH ID Number:
Provider/Contractor:	Clinician:
Auditors:	
Service Setting:	Specified Service Rendered:
Dates of Service Billed:	
Does the bill code match the note content: Y / N	Do service dates match progress notes: Y / N
Resolution if answered "No":	
Date corrected and by whom:	
Are there National Provider Identifier (NPI) numbers for every credentialed provider (Social Service Workers and licensed health care providers)? Y / N	
Is there documentation that The List of Excluded Individuals/Entities (LEIE) Office of Inspector General (OIG) List and the System Award Managment (SAM) database have been compared monthly and checked for a match against every credentialed provider on the provider list. Y / N Any exclusions found? Y / N	

I. TREATMENT PLAN	(check one) Yes	No	n/a
1. Does the tx plan address the current problem?			
2. Are the tx plan objectives measurable?			
3. Are all modalities listed on the tx plan being utilized?			
4. Is the tx plan signed and with credentials?			
5. Is there a projected schedule of service delivery, including frequency & duration?			
6. Is the diagnostic section complete on all five axes?			

II. MEDICATION MANAGEMENT	(check one) Yes	No	n/a
1. Do notes specify progress toward goals and objectives?			
2. Does the record contain a current list of medications?			
3. Has the client been seen in the last 180 days?			
4. Is the diagnostic section complete on all five axes ?			

III. CLINICAL NOTES	(check one) Yes	No	n/a
1. Do notes specify progress toward goals and objectives?			
2. Do notes adequately document the service?			
3. Has the client been seen in the past 90 days?			
4. Do the notes justify continued treatment?			
5. Do goals on the progress notes meet goals on the tx plan?			
6. Identification of desired changes stated in behavioral terms?			
7. Do notes include date, time & duration of service?			

Comment on any areas answered "No" by noting section and question number.

(NOTE ON THE BACK OF THIS FORM HOW YOU FIXED THE PROBLEM)

ASSESSMENT OF OVER/UNDER UTILIZATION OF SERVICES

(CHECK ONE BOX)

Amount, duration, and scope of services seen adequate.		Amount, duration, and scope of services seen marginal.	
Amount, duration, and scope of services seen excessive.		Amount, duration, and scope of services seen inadequate.	

Comment regarding over/under utilization of services:

Quality improvement recommendations:

Other comments/recommendations:

AUDITOR SIGNATURE:	DATE:

Wasatch Mental Health - Medical Staff Peer Review A-3.04			
WMH Client File #:	Date:		
Clinician:			
Treating Medical Staff:			
Auditor:			
I. Clinical Assessment	Medicaid		
	Yes	No	Comments
1. Five Axis Diagnosis present?			
2. Symptoms supporting diagnosis identified?			
3. There is a documented diagnosis or indication for each medication?			
4. Labs obtained and review results documented by signature and date?			
5. Changes in target symptoms documented in progress note?			
6. Is the Medication Informed Consent form completed?			
7. Safety issues evaluated-suicidality, homicidality, and psychosis?			
8. If safety concerns are present, a safety plan is documented?			
9. Treatment plan reviewed and signed every 180 days			
10. AIMS completed?			
11. Is treatment progress documented?			
II. Collateral Contacts	Yes	No	Comments
1. Are there any documented contacts with other treatment providers?			
2. Are there other medical concerns?			
3. Are ther other treatment concerns?			
4. If there are other concerns, have they been addressed?			
III. Over/Under Utilization of services	Yes	No	Comments
1. Does the amount, duration and scope of services seem adequate?			
IV. Dual Diagnosis	Yes	No	Comments
1. Is there a co-existing condition (Mental retardation, substance abuse, acquired train injury, etc.)			
2. Has the co-existing condition been assessed?			
3. Is the co-existing condition being treated?			
Feedback to prescriber:			
Please comment on any areas answered "No" by noting section and question number:			
Please comment regarding Over/Under Utilization of Services:			
Quality Improvement Recommendations:			