

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, 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. 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 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 instruments (A - #

3.02a and 3.02b Chart Review Forms – See sample attachments) 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 Crisis and Intensive Services who shall act as Committee Chair. The Chair shall select committee members. Members shall include case managers, program managers, and supervisors of both Clinical and Community and Crisis and Intensive 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 share the information learned during the meetings with the staff with whom they work. They shall make sure that each staff member reviews one client's chart by another peer from their program. The committee shall meet no less than quarterly for 1 hour. During each meeting, the clinical records which have been reviewed shall be reported. The identified auditing (*A - # 3.02a and 3.02b Chart Review Forms – See sample attachments*) shall be used to audit the charts.
3. Peer Review Sub-committee members shall ensure the auditing instrument is completed. 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 WBH Corporate Compliance Officer (*See policy C-3.13 WBH 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 (*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.

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 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 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 – 3.02 a HHS Chart Review Tool – Adults

A – 3.02b HHS Chart Review Tool – Youth

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.

Adult Mental Health

Center: _____ Site: _____ Date: _____

ID#: _____ Age: _____ Insurance: _____ Division Reviewer: _____

ASSESSMENT

Presenting Problem: _____

Focus on immediate needs of client: _____

Recommendations respect/note client choices: _____

C-SSRS/Safety Plan if indicated? _____

Is the Safety Plan easily accessible? _____

Is there a plan for coordinated follow up care if indicated? _____

Readable _____ Trauma History _____ Treatment History _____ Strengths-focused _____

Administer OQ _____ OQ as intervention _____ Culture considered _____

Ongoing Assessment _____

DIAGNOSIS

DSM-V/ICD-10: _____

Sample Form

Symptoms supporting diagnosis? _____

PERSON-CENTERED RECOVERY PLAN

Recovery Focused/Individualized: _____

Consumer's Life Goals/Motivators: _____

Person-Centered Treatment Goals: _____

Barriers: _____

Strengths: _____

Utah Division of Substance Abuse and Mental Health Children, Youth, and Family Chart Review Tool		
Center: _____	Site: _____	Date: _____
Center Designee: _____	Division Reviewer: _____	
MONITORING/CHART ITEMS		
Identification Number: _____	Medicaid Recipient: _____	
Gender: _____	Age: _____	
Evidence of Trauma Assessment _____	Evidence of Risk Assessment _____	
Suicidal/Homicidal or Self-Harming _____	b. Evidence of a Crisis/Safety Plan _____	c. Has a copy has been offered/given to _____
YOQ Every 30 Days? _____	If Not, how often? _____	YOQ used Clinically? _____
Presenting Problems/Issues/Symptoms:		
Sample Form		
Diagnosis:		
		Comments:
Date of Asesement/Update		
Current Assessment		
Child/Youth Strengths		
Recovery & Resiliency (natural/informal)		
Family Strengths		
Co-morbid Assessed (SUD/ID/DD/etc)		
Family/Guardian Functioning		
Social Functioning		
Education Functioning		

WBH OUTSIDE CONTRACT CLINICAL RECORD AUDIT INSTRUMENT			
Client Name:		WBH 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 Management (SAMS) 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			
Are Outcome Questionnaires submitted monthly? 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 diagnosis complete in appropriate DSM-IV or DSM-V format?			
II. 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:	

Sample Form

Wasatch Behavioral Health - Prescriber Audit			
WBH CLINICAL RECORD AUDIT INSTRUMENT			
Client Name:		WBH ID Number:	
Provider/Contractor:		Clinician:	
Auditor:			
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 Management (SAMS) 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. Clinical Assessment	Yes	No	Medicaid Comments
1. Accurate 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. Safety issues evaluated-suicidality, homicidality, and psychosis?			
7. If safety concerns are present, a safety plan is documented?			
8. AIMS completed if needed?			
9. 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 there 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?			
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:			
AUDITOR SIGNATURE:		DATE:	

Sample Form