

## **POLICY TITLE: Utilization Management Review Policy- Level I Adult Service Teams**

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This policy presents a revised utilization review process for non-hospital level I adult system of care Service Team providers. The purpose of following utilization management policy and procedure is to improve both the efficiency of the process and the management of the content and quality of clinical records within ACBHCS while maintaining its effectiveness. The procedures described entirely replace the existing utilization review process. The policy makes structural changes in the utilization control system, transferring responsibility for the utilization review of clinical records component to the provider with oversight and audits conducted by the ACBHCS Quality Assurance Administrator.

At the time of implementation of Consolidation Phase II, the State Department of Mental Health revised the utilization management regulations. They do not require counties to have either a coordinated care or traditional utilization review system. Within our current system, we have two departments responsible for authorization: the Quality Assurance Office and the Authorization Unit. If the new proposed structure is adopted, there is a separation of the quality review of mental health records from the authorization component. Initial authorization for services will continue to be the role of ACBHCS ACCESS. Quality and Utilization Review will be the responsibility of the provider sites with oversight by the Quality Assurance Administrator.

For clarity, quality review consists of examining client records for medical necessity, clinical appropriateness (service necessity) of services, documentation completed in accordance with regulation, standards, and requirements, and assuring maintenance of clinical records in accordance with state and federal laws, regulations, and standards.

As indicated in the *Background* section below, one function of the new policy is to reduce duplicative work for supervisors and clinicians. It empowers supervisors and *holds them responsible* for staff's performance. The system integrates well with other quality assurance measures, such as peer review, and it ensures that every clinician will receive continuous supervision with corrective education/training as necessary. Although this system will not eliminate errors, it should improve the quality of clinical record documentation and minimize the error rate.

### **BACKGROUND**

The original utilization review system began in 1989 and adopted utilization control regulations in accordance with requirements of the State Department of Mental Health's Short-Doyle/Medical Manual for the Rehabilitation Option and Targeted Case Management. Initially, the utilization review process was conducted at each provider site with a utilization review coordinator responsible for the organization and coordination of the system. In the autumn of 1993, the structure of the utilization review process evolved to a centralized Utilization Review

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Committee comprised of both county operators and contracted providers. The Quality Assurance Administrator was designated as the Utilization Review Chairperson responsible for the coordination of the overall process. Except for minimal regulatory changes, utilization control regulations have remained unchanged. Utilization Review, whether conducted at *the* provider site, or within the centralized URC has always addressed both the authorizations for continued services and clinical documentation compliance of mental health records. By anecdotal reports, even though clinicians are adhering to the current utilization control regulations and protocols, it is estimated that eighty percent (80%) of the clinical records are not reviewed by the centralized utilization review committee. Consequently, a sampling restricted to twenty percent (20%) of all medical records became a standard way of monitoring compliance with documentation standards. This may not be an effective mechanism for several reasons:

1. The 20% sample does not include a periodic review of all clinicians' clinical records and their documentation practices. Many clinicians schedule their clients so that they stay within utilization control intervals and need not ever submit their clinical records to URC.
2. Subsequently, if the amount of services rendered to clients is determined by any other reason, except clinical, the consumer is not receiving services in accordance with his/her clinical needs.
3. The clinician is allowing administrative requirements to become a clinical variable in determining how treatment shall be rendered.
4. If services are withheld or not documented because the clinician does not want to exceed a certain amount of services in a certain period of time, this can impact the fiscal operations in the organization in various ways: (A) Revenues are lost for services not being documented, or (B) Clinically necessary services that could have been provided were not, which is a loss in revenue in the outpatient services, and/or (C) Clients may experience relapses and require more frequent hospitalizations which is a higher and more costly level of care.

The following policy restructures the utilization review component of the ACBHCS Utilization Management Program to account for these weaknesses.

### **REVISED POLICY**

ACCESS will continue to screen all cases and provide initial approval for consumers to receive Level I outpatient services. Those consumers who are authorized for this service will be assigned to a Service Team Program. Provider sites will continue to adhere to all quality assurance requirements including the peer review process. All medication only cases will continue to be monitored and reviewed by the current medication monitoring process directed

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by ACBHCS's Medical Director's Office. This revised policy will modify only the current Utilization Review Process for Adult Level I Outpatient Services except for clients served only by the Medication Program. The quality and utilization review process becomes the responsibility of the providers for the first level of review. The second level of this review consists of the ACBHCS Quality Assurance Administrator (or designee) conducting a review of clinical records annually by selecting a sample of those records. In addition, ACBHCS may contract with an outside independent reviewer to periodically sample charts.

### **UTILIZATION MANAGEMENT REVIEW PROCESS OVERVIEW**

Attached are the Utilization Control Data Input Procedures for Level I Mental Health Providers. A treatment plan must be completed within thirty (30) days from the episode opening date. Upon completion of the initial treatment plan, a **Plan Approval** (TPR) must be entered into the INSYST-electronic system. TPR/Chart Reviews are required every six months based on the first day of the month of episode opening. Upon completion of the TPR/Chart Review, an action is entered into INSYST.

#### **The Provider Site First Level Review**

At the provider site, a designated supervisor will review each client's records and services every six months. *With the approval of the QA Administrator provider sites with large active caseloads may petition to conduct a sequential 50% sample of open charts, such that every chart will be reviewed annually by the provider in one of the two six-month reviews.*

#### **ACBHCS Second Level Review**

The ACBHCS Quality Assurance Administrator, or designee, will review a sample of clinical records annually. These annual reviews will be conducted at the provider sites.

### **UTILIZATION MANAGEMENT REVIEW PROCEDURE**

#### **Provider Site First Level Review**

Each client's chart and services provided will be reviewed every six months (or annually with the approval of the QA Administrator, as outlined above) at the Provider Site by a designated supervisor.

- > Every client's chart will be reviewed at the time of Assessment, Treatment Plan, or Treatment Plan Update.
- > The supervisor, or designee, will sign the Assessment, Treatment Plan, or Treatment Plan

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Update indicating that he/she has done a retrospective review of the chart, thus approving the service plan for the subsequent cycle. The signature of the Supervisor, or designee, also indicates that all quality assurance requirements have been met and the site approves the utilization management plan.

### **ACBHCS Second Level Review**

On an annual basis, the ACBHCS Quality Assurance Administrator, or designee, will schedule to review a random sample of charts at the provider site. Providers will be notified of their impending ACBHCS review; however, prior information about which mental health records have been selected will *not* be conveyed.

ACBHCS will randomly select one (1) chart per fifteen (15) of the open caseload of each clinician (at least two (2) charts per clinician). If the open caseload list is generated prior to the date of the review, the randomly selected charts will be reviewed regardless of whether the case remains open or was recently closed.

- Each of the selected cases will be reviewed according to the elements on the checklist.
- One copy of the completed checklists will be provided to the provider.
- One copy of the completed checklists will be retained by the Quality Assurance Administrator (or designee) for the purpose of developing a report of the findings.
- If clinical records are not in accordance with either ACBHCS's or California State Department of Mental Health's standards, a plan of correction will be required. The provider will be responsible for completing the corrections and submitting the clinical records within thirty (3) days to the ACBHCS Quality Assurance Office for review of the corrections.
- If utilization management concerns arise in the process of review, or at any time during the year, then ACBHCS may elect to review additional clinical records at any time.
- Error Rate and Plan of Corrective Action: **A 10% error rate** will trigger a Plan of Corrective Action. If errors discovered fall below 10%, this information will be submitted by the provider with an expectation that corrections will be completed. Each question on the Quality Management and Utilization Review Checklist is assigned a value and the error rate is determined by the total number of errors compared to the total score.
- When triggered, a Plan of Corrective Action will be formulated by the supervisor and

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sent to the Quality Assurance Administrator for approval. When a Plan of Corrective Action is approved, the supervisor will be responsible for its immediate implementation.

- Further sampling and accountability measures may be introduced at the discretion of the Quality Assurance Administrator.

**DOCUMENTATION OF REVIEWS**

**First Level Provider Site Supervisor Review:** The signature of the supervisor, or designee, on Assessment and Treatment Plans indicate review and approval.

**Second Level ACBHCS Sample Review:** The Quality Assurance Administrator, or designee, will sign the attached checklist for each chart that is reviewed. A summary of findings will be maintained by the Quality Assurance Administrator and a copy will be provided to the Center/Executive Director and the Associate Director of Adult Services at ACBHCS.