ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

External Protocols for
FY14 Post-Payment Review

Scheduling of Reviews

During FY14, DHS/DMH specified Williams class providers will receive a Post-Payment Review (PPR). This review will not be coordinated with BALC Certification reviews. The Collaborative Clinical Coordinator is responsible for developing the review schedule. The confidential review schedule is distributed by the Collaborative Training Coordinator.

The billing period for which claims are pulled begins 12 months prior to the date the claim run is developed and ends with the date the claim run is developed. 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 Clinical Coordinator 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 Clinical Coordinator needs to be notified. It will be this individual's responsibility to make the final decision as to whether or not the scheduled review dates will be changed.
All reviews will continue to be announced. A claim run will be collected and organized prior to the review, 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

The PPR Tool is 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 http://www.dhs.state.il.us/page.aspx?item=60857 .

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 (Rule 132).

Sampling Methodology and Claim Review Period

Post Payment Review

In order to establish a sampling methodology for post-payment review (PPR) for FY14, 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 begins 12 months prior to the date the claim run is developed and ends with the date the claim run is developed 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.
- OAS 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 FY14:

1. A statistically sound random sample of all adjudicated claims per specified provider will be selected for post-payment review using the specified OAS RAT-STATS, 2007, version 2, Software.

2. The sample of claims will be determined using the sample calculator within OAS 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 OAS 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.

Notification of Results, Follow-up, Plans of Improvement

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 Rule 132, revised December 2012.

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 Rule 132, revised December 2012. An additional review will be required to ensure that corrections have been made to ensure compliance with Rule 132. 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.

Policy Pertaining to Conflict of Interest

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

The Collaborative Clinical Coordinator maintains an updated list of providers who would pose a conflict of interest situation for specific Regional Liaisons. The Clinical Coordinator 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 Clinical Coordinator who will also notify DHS/DMH.

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. 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.

7. 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 DHS/DMH Regional Director and Collaborative Clinical Coordinator are also to be notified by the Regional Liaison. If the provider refuses to file a report, the Regional Liaison is required to do so.

8. 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 uncredentialed staff dispensing medications. Within four hours the Collaborative Clinical Coordinator must be notified by the lead Regional Liaison, who will then contact DHS/DMH and appropriate DHS/DMH regional staff.

9. 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.

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

11. 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:

1. The Lead Regional Liaison will identify him/herself to the provider receptionist and ask to speak with the provider contact person
2. The review team will conduct an entrance conference with the provider contact person, Program or Clinical Director, and other staff the provider deems important.
3. 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.

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 DHS/DMH Provider Monitoring Review Questionnaire and self-addressed stamped envelope to the provider contact person. This is a survey where providers can give their feedback on the

process. Inform the provider that the questionnaire is also available for on-line completion on the Collaborative website.

Transportation of Confidential Records

All reviewers must comply with the ValueOptions Policy: LC403 – Safeguards for the Secure Transmission and Use of Confidential Information Off-Site, Revised 12/17/09.