


# PBH QUALITY MANAGEMENT

Licensed Independent Practitioner (LIP)  
Profile Review Process



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Information provided in this presentation pertains only to the counties in the PBH Region. This information is specific to the PBH region and may not apply to Local Management Entities (LMEs), providers, stakeholders or individuals outside the PBH catchment area.

Presentation slides are brief, bullet-points of information and should not be used out of context.

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# MONITORING PROCESS OVERVIEW

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- Initial Review
  - On-site assessment
- Preliminary Status/Implementation Review:
  - Served PBH consumer for 90days
  - Implementation review score of 85%
  - Reviewed annually
- Advancement to Preferred Status
  - Eligible after successful completion of 90 day Preliminary review with a minimum score of 85%
  - Reviewed every 3 years
  - Maintain review scores between 85% to 100%
  - Returned to Preliminary status for one year until next review if 85% is not met

\*Review scores below 75% are evaluated by the PBH Credentialing Committee\*

# LIP PROFILE GRID

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<b>Status</b>	<b>Duration of Service Provision:</b>	<b>Achieve a review score of:</b>	<b>Frequency of review:</b>
<b>Preliminary</b>	<b>90 days or less</b>	<b>below 85%</b>	<b>Annually</b>
<b>Preferred</b>	<b>90 days or more</b>	<b>85% - 100%</b>	<b>Every three years</b>

# INITIAL REVIEW

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- Initial on-site review tool
- Initial on-site review guide
- Initial tool is used when: entering network, change of address, adding an additional site
- Review forms can be found on line:
  - <http://www.pbhsolutions.org/>

## ELEMENTS OF ON-SITE REVIEW

- State Standards
- NCQA
- HIPAA/Confidentiality
- NCQA & PBH
- State Standards/Client Rights
  - Consent for treatment
  - Authorization to release information
  - Notifications of consumer rights
  - Notification of grievance process
  - Consumer treatment plan
  - Progress/treatment notes

# ELEMENTS OF ON-SITE REVIEW- CONTINUED

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- Compliance with Record Standards
- Confidentiality of Treatment Records
- Documentation Standards
  - Presenting Problem
  - Mental status exam
  - Psychiatric history
  - Special Status situations/Suicide Risk
  - Medical History
  - Developmental/Education history for Minor
  - Medications
  - Allergies
  - Preventive services/risk screening
  - Documentation of clinical findings and evaluation of each visit

## ADDITIONAL SITES/CHANGE OF ADDRESS

Steps to adding an additional site or moving sites:

- Contact PBH Provider Relations/Network Management
- QM Department completes on-site review tool

\*Network and QM should be contacted before services are provided to a PBH consumer at any new site/location\*

# SCHEDULING OF PROFILE REVIEWS

- 4-6 weeks prior to review
- Confirmation of main contact and location
- Electronic Records
- Review of scheduling form

## PRELIMINARY/PREFERRED STATUS REVIEW

- LIP Review Tool
- LIP Review Guide
- Same tool used for both Preliminary and Preferred
- Review forms can be found on line:
  - <http://www.pbhsolutions.org/>

## REVIEW TOOL ELEMENTS

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- Consent for treatment
- Authorization to release/disclose form
- Record Storage/Confidentiality
- Grievance Process/system
- Service Plan
- Consumer Satisfaction Survey
- Cultural Competency Plan

## CULTURAL COMPETENCE CATEGORIES

- Category 1. Licensed Independent Practitioners
- Category 2. Family/Home, AFL provider
- Category 3. 14 or less FTE's and infrastructure does not separate roles of administrative and service
- Category 4. 15 or more FTE 's and infrastructure separates the roles of administrative and service

## CULTURAL COMPETENCE INITIATIVE

- Part of the PBH quality initiative is to conduct Cultural Competence reviews for providers.
  - Cultural Competence reviews are completed as part of the quality assurance monitoring activities to ensure contract compliance.
  - Reviews are completed during the Performance Profile Review Process.
- \*resources and links regarding Cultural Competence can be found at [www.pbhsolutions.org](http://www.pbhsolutions.org)

# CONSUMER RIGHTS

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Consumer Rights as defined in NC laws and rules.

Reference **APSM 95-2, G.S 122-C:**

- Consumers/LRP should be informed of rights at intake
- Written discharge plan at time of discharge
- Contact and Consult with Legal Council, Private Physician and Private MH/DD/SA Professional of choice
- Consumer Advocate
- Receive necessary treatment

## CONSUMER RIGHTS-CONTINUED

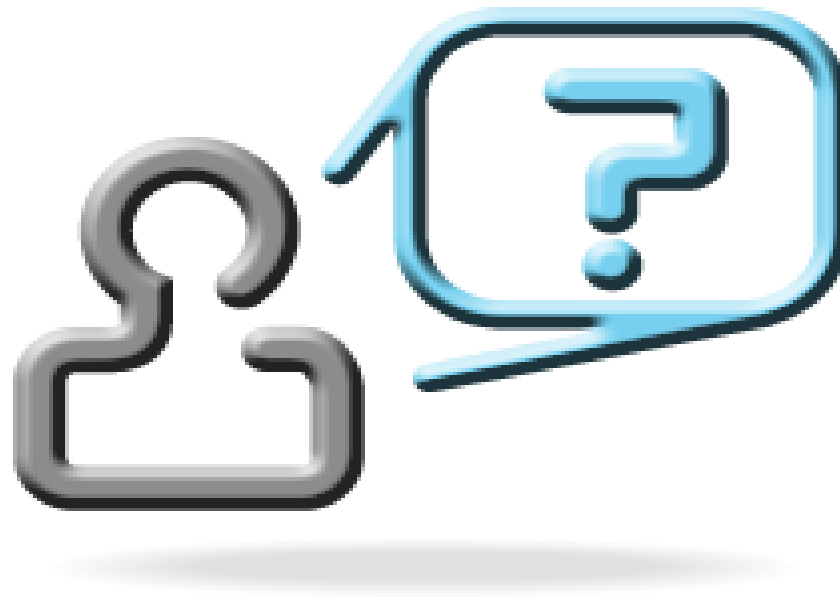
- Each person has a right to be treated with dignity and respect.
- Confidentiality
- Request a listing of disclosures
- Request restrictions on disclosures
- To be free from abuse, neglect, and exploitation
- Consumer or LRP shall be informed of:
  - The alleged benefits, potential risks, and possible alternative methods of treatment/habilitation
  - Length of time consent if valid
  - Procedures to withdraw consent

## CONSUMER RIGHTS-CONTINUED

- How to get a copy of their treatment and/or discharge plan
- Program rules and consequences for violation
- Receive a copy of Notice of Privacy Practices
- How to file a complaint or a grievance - including who to contact and timelines
- Review and receive a copy of health information
- Request amendment of health information
- Fees and collection practices

# Questions

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# AUDIT PROOF YOUR SERVICES

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Recommendations and Best  
Practices

pbH

*Creating solutions, One person at a time*

# TRAINING OBJECTIVES

The Who, What, When, Where and How

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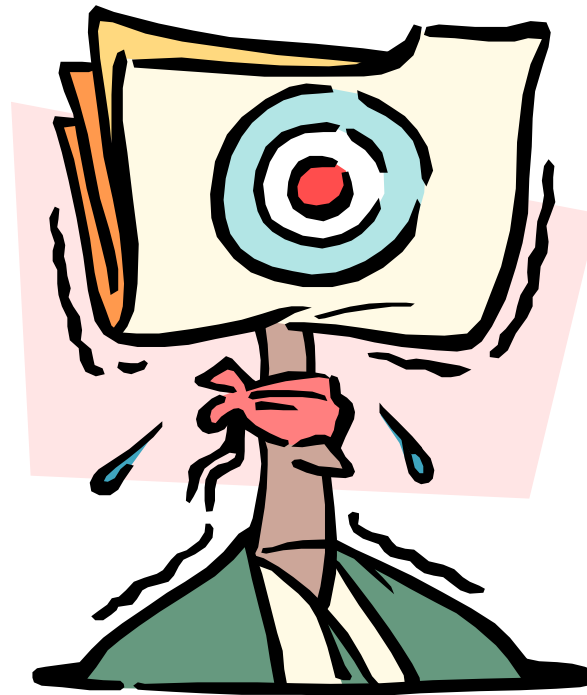
- **WHO** is required to receive a billing audit
- **WHAT** will be reviewed during the audit
- **WHEN** to expect your agency's audit
- **WHERE** to look for rule changes
- **HOW** to prepare for a PBH audit

# WHY AUDIT RECORDS?

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- Liability
- Share information
- Ensure services are being provided
- Compliance with rules / regulations

# BILLING AUDITS



# PBH BILLING AUDITS

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The PBH Billing Audits are conducted as part of Quality Assurance monitoring activities outlined in the waiver agreement and our contracts with the state.

To ensure compliance with:

Federal rules

State rules

Medicaid rules

Waiver regulations



# PBH BILLING AUDITS

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All contracted providers who bill PBH for services will be audited.\*

## Timeframes:

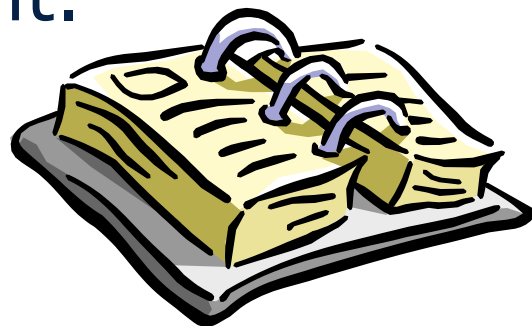
Reviews may be annually or up to three years based on the PBH Provider Performance Profile Star System.

\*Exception: LIP providers are audited once they reach 10 paid claim managed visits

# SCHEDULING BILLING AUDITS

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- Quality Management staff will contact the provider 4-6 weeks in advance to schedule the audit.
- A letter will be sent to the provider detailing what will need to be made available to the auditors on the day of the audit.



# AUDIT TYPES

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- Implementation
- Provider/LIP Performance Profile
- Focused
- Contract Termination
- Justified Cause

# IMPLEMENTATION AUDITS

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- An Implementation Audit can be conducted when:
  - a new contracted Provider enters the PBH network, and/or
  - a contracted Provider has been approved to provide an additional service.
  
- 10 dates of service are reviewed

# PROVIDER PERFORMANCE PROFILE AUDITS

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- Routine - 30 events
- Preferred - 20 events
- Exceptional - 15 events
- Gold Star - 10 events

# FOCUSED AUDIT

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- A Focused Audit can be conducted when:
  - new or revised service definitions/rule changes occur, or
  - when concerns arise regarding service delivery with a specific service.

# JUSTIFIED CAUSE AUDITS

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- As a result of previous issues cited/noted during a Scheduled Billing Audit, or
- As part of an investigation when complaints are received regarding billing irregularities, potential fraudulent billing or documentation.

# CONTRACT TERMINATION AUDIT

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- Upon notice of contract termination, and prior to final payment, the LME will perform a Contract audit to ensure that all Contractual and other fiscal requirements have been fulfilled.
- Applies to Provider Initiated contract termination and PBH Initiated contract terminations

# Service Plans

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#1. An appropriate service plan is current with the date of service.

#2. An appropriate service plan identifies the type of service billed.

# SERVICE PLANS

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- Effective Date of Plan
- Needs/strengths/preference
- Goals
- Specific service intervention with frequency, duration
- Responsible person
- Target date that does not exceed 1 year from plan
- Signatures of all parties

# Service Order/ UM Authorization

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#3. There is a valid service order and/or Utilization Management authorization for the service billed.

# SERVICE ORDER/UM AUTHORIZATION

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- Authorization from Utilization Management is required for managed visits.
- Service order must be signed by the appropriately licensed professional on or before the date that the service identified in plan is initiated, ex. MD, DO, Licensed psychologist [Health Services Provider—Psychologist (HSP-P)], NP, or PA

# Service Notes

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#4. Full signature of the person who delivered service is present and includes position/credentials.

#5. The service documentation reflects purpose of contact, staff intervention, and assessment of progress towards goals.

# Service Notes

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#6. The service note relates to goal(s) listed in the service plan.

#7. The service note is individualized per consumer and is not duplicated elsewhere in the record.

# SERVICE NOTES

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## Service Notes requirements:

- Full date of service (month/day/year)
- Duration of the service
- Purpose of the contact as it relates to a goal in the service plan
- Description of the activity/intervention
- Assessment of consumers progress towards goals
- Handwritten signature and credentials, degree or licensure

# Duration of Service

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#8. Service documentation reflects treatment for duration billed.

#9. Units billed correspond with duration documented on service note.

# Staff Qualifications

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#10. There is documentation that the staff is qualified for the service being provided. Staff is credentialed through PBH.

# PROVIDER SELF-AUDIT

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- Lack of Service Order or UM Authorization
- Invalid Service Plan
- Clinician not credentialed through PBH

*Self-audit may include dates of service for one year from the date of service being reviewed.*

# PROVIDER SELF-AUDIT

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- PBH will prepare the self-audit, *OR*
- The Provider will review their own documentation for compliance with rules and regulations. PBH will provide the LIP with:
  - The date range for service documentation review
  - Self-Audit Tool
- Self-Audit is required to be completed within 30 days from receipt/request of the review findings

# SELF-AUDIT TOOL

## PIEDMONT BEHAVIORAL HEALTHCARE PROVIDER SELF AUDIT FORM

<b>PROVIDER AGENCY:</b>	<b>DATE OF PBH AUDIT:</b>	<b>DATE OF SELF AUDIT:</b>
<b>CONTACT AT PROVIDER AGENCY FOR QUESTIONS:</b>	<b>CONTACT NUMBER:</b>	<b>SUBMITTED BY:</b>

CONSUMER NAME	CLAIM NUMBER	PROCEDURE CODE	DESCRIPTION OF SERVICE	DATE OF SERVICE	UNITS BILLED	UNITS TO PAYBACK	CALCULATED PAYBACK	PAYBACK REASON CODE	FUNDING SOURCE (MEDICAID/ STATE)
						Total	\$ -		

### PAYBACK REASON CODES

1 - Staff not privileged to provide service billed.	10 - No documentation of effectiveness	Comments:
2 - Staff supervision plan not implemented as written.	11 - Units billed do not match authorized units	
3 - No valid service order	12 - Treatment does not reflected for duration billed	
4 - Service plan not valid for date of service	13 - No note for event billed.	
5 - Service billed is not identified in plan	14 - No supervision contract	
6 - Activity billed is not a billable service	15 - Other	
7 - No appropriate signature on documentation	16 - No HCR check prior to working with consumer	
8 - Documentation does not relate to goals	17 - No criminal background check completed	
9 - No documentation of intervention	within required timeframe.	

# BE PREPARED!

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- Read scheduling letter and have all requested items available *before* the auditors arrive
- Flag requested items from the scheduling letter such as supervision contracts, HCR checks, service orders, etc. so the auditors can easily access this information

# ITEMS FOR AUDIT

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## ITEMS NEEDED FOR THE THREE MONTH PERIOD BEING AUDITED

- Service Plans
- Service Notes for all services
- Required authorizations / orders for services
- Billing documentation

# FALSE STATEMENTS

18 U.S.C. 1035 / 42 U.S.C.A. 1320a-7b (1991)

/ NCGS 108-63

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It is a crime to knowingly and willfully:

- Falsify or conceal a material fact
- Or make any materially false statement
- Or use any materially false writing
- Or document in connection with the delivery of or payment for health care benefits, items or services

# FALSE CLAIMS ACT

31 U.S.C. 3729-3733



*Creating solutions, One person at a time*

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A claim for payment for services or supplies that were not provided specifically as presented or for which the provider is otherwise not entitled to payment.

Prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim for payment or approval.

# PBH REVIEWER SURVEY AND FEEDBACK FORM

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- Survey provided following PBH audit
- Submit to Director of Quality Management
- Results are analyzed for trends/patterns
- Confidential
- Reviews aid PBH in improving system

# RULES / GUIDELINES

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- APSM 30-1: “The Rules”
- APSM 1026: Service Definitions Manual
- APSM 45-2: Service Records Manual
- APSM 95-2: Client Rights Manual
- Medicaid Guidelines and Communication Bulletins
- PBH Cardinal and Innovation Waiver Manuals
- Agency Contract with PBH

[www.dhhs.state.nc.us/mhddsas/manuals](http://www.dhhs.state.nc.us/mhddsas/manuals)

[www.ah.dcr.state.nc.us/records/local/default.htm](http://www.ah.dcr.state.nc.us/records/local/default.htm)

# Concerns/Grievances

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- For concerns, requests, suggestions for better services or grievances contact: Anonymous concern line: 1-888-213-9687