Washington County Health and Human Services (WCHHS)
Behavioral Health Program

Utilization Management: Retrospective Clinical Records Review

Policy Number:	WCHHS-BH 119
Responsible Team:	Utilization Management
Origination Date:	01/01/2015
Next Review Date:	05/01/2020
Revision history:	12/08/2014, 02/15/2017, 05/11/2018, 05/01/2019

Related Documents: Utilization Management Policies

Approved: Kristin Burke Digitally signed by Kristin Burke Date: 2019.05.01 12:57:19 -07'00'

Division Manager

OBJECTIVES

Washington County conducts chart reviews of its contracted providers to ensure clients are assigned to the appropriate level of care and that services provided are matched in type and intensity to the client's individuals need.

SCOPE/APPLIES TO

Washington County Health and Human Services contracted providers

POLICY

I. **Policy Statement**

Provider will manage utilization throughout the authorization period to ensure that the client is assigned to the correct level of care as indicated by medical necessity and that the services provided are consistent with that level of care. In situations where the Provider has reached the maximum dollar amount for the authorization prior to the end of the authorization period, and the client does not qualify for a higher level of care, the Provider is expected to continue to provide medically necessary services.

Utilization management is a primary responsibility of contracted providers. Certain utilization management activities will be conducted by a WCHHS Care Coordinator at times and intervals indicated by the specific service and level of care. Utilization management will also take place when transfers between levels of care are requested.

Washington County Care Coordinators will also monitor utilization and treatment through regular retrospective clinical record review, as well as site visits or attendance at treatment team meetings at their discretion.

A. **II. Procedure** General Fund Contracted Services

Washington County will perform a minimum of one retrospective clinical record review per calendar year, per program that serve 20 or more members. However, all providers may be reviewed at any time at the department's discretion A minimum of 8 records or 2.5% of the total General Fund authorized clients per program each calendar year, whichever is greater, will be reviewed. Programs that have less than 40 clients enrolled in treatment with General Fund treatment authorizations at the time of the review will have a minimum of 5 clinical files reviewed per year.

Records will be selected in the following manner:

- A minimum of two records that have low billing to cap ratios
- A minimum of two records that have high billing to cap ratios
- A minimum of four randomly selected records

In programs where there are multiple levels of care (i.e. rehab and child outpatient), files will be selected in the following manner:

- A minimum of two records that have low billing to cap ratios from each level of care
- A minimum of two records that have high billing to cap ratios from each level of care
- A minimum of two records where the client's level of care was changed mid-auth period (unless no level of care changes occurred)
- A minimum of six randomly selected records

The chart selection methodology may change based on concerns or needs identified by program staff. For programs that serve both OHP and General Fund clients, care will be taken to ensure that records from both funding sources are reviewed.

Programs other than Outpatient and Rehabilitation will be reviewed at the discretion of the Program Coordinator/ Program Supervisor.

Reviews of all programs will focus on the following areas:

- Clinical match between the client's clinical needs and the level of care to which the client is assigned
- Coordination of care with PCP and other providers
- The "Golden Thread" where the progress notes reflect implementation of the treatment plan and the treatment plan is directly related to the presenting clinical concern as documented in the mental health assessment.

Each record review will be documented using the Utilization Management review form. This form will be completed in the process of the review and kept on file for seven years for future reference. Providers will receive a copy of the review and will be provided an opportunity to correct concerns identified in the review, if possible. If there are serious concerns identified, Washington County may

require a written improvement plan and /or require that existing authorizations be modified to reflect the clinically appropriate level of care.

If during the initial annual review there are areas of concern identified, a follow up review will be conducted later in the year. These will typically be scheduled six months after the initial review. If there are no areas of concern identified, the program will not have another retrospective review until the following year.

If, during the course of the review, any of the following are found: chronic concerns present for more than 2 reviews, intentional misrepresentation, repeated mis-assignment to a level of care higher than indicated, pattern of missing or late documentation, or suspected incidents of fraud or abuse, consistent with WCHHS_QA_BH_022 Fraud and Abuse policy, Washington County will take immediate action. A comprehensive site review will be conducted with a representative sample of all Washington County files. This site review may result in a corrective action plan, reimbursement of paid claims, or contract termination.

B. **Oregon Health Plan/Health Share Outpatient and Rehabilitation Authorizations**

For Oregon Health Plan / Health Share members, their charts and clinical documentation will be reviewed as documented in the Regional Behavioral Plan Partner policy: HSRMH-110 Clinical Chart Review and Claims Audit.