SECTION X – QUALITY IMPROVEMENT

The Local Mental Health Plan (LMHP) has a responsibility and shared commitment with network providers, to maintain and improve the quality of the service delivery system. It is a function of the LMHP to support this commitment by establishing processes for the resolution of service and system issues and the continuous improvement of the delivery of specialty mental health services.

The LMHP quality improvement activities focus on each of the following areas:

- Service accessibility
- Service delivery capacity
- Medi-Cal beneficiary satisfaction
- Network provider satisfaction
- Appropriateness of care
- Continuity of care
- Coordination with health care
- Utilization management
- Adverse outcomes
- Credentialing and peer review

NETWORK PROVIDER RESPONSIBILITIES

- Compliance with the terms and conditions of the LMHP Medi-Cal Professional Services Legal Agreement, Exhibit A of the Legal Agreement (Service Provisions) and the requirements in the LMHP Provider Manual and Provider Bulletins;
- Compliance with all relevant Federal, State and County statutes, rules and regulations;
- Maintenance of all clinical records and PHI shall be retained for a period that is at least equivalent to the later of any of the following:
    - 10 years following the conclusion of services;
    - For minors, until such time as the minor reaches 25 years of age (Refer to DMH, Clinical Records Maintenance, Policy Number 401.01);
    - 10 years after completion of all County, State and/or Federal audits; or
    - 10 years after the conclusion of any audit appeal and/or when audit findings are fully resolved.
- Ensuring availability of all clinical records during normal business hours to authorized representatives of the Federal, State and County government for the purposes of inspection, program review and audit;
- Coordination of care with other treating mental and physical health care providers which should, at a minimum, include information exchange regarding treatment planning and medications;
- Emergency coverage at all times;
- Reporting of adverse incidents to the LMHP;
- Prompt response to requests from the LMHP Credentialing Review Committee; and
- Immediate notification to the LMHP of any accusations or actions against the network provider's clinical license, including, but not limited to, license suspension or termination.

COMPLIANCE PROGRAM REVIEWS AND PROGRAM INTEGRITY

Pursuant to the Medi-Cal Professional Services Agreement with Individual and Group Providers, the Compliance Unit of the Health Care and Integration (HAI) Division, has a right to access, review and to copy any records and supporting documentation pertaining to the performance of the Agreement during normal business hours. The Outpatient/Inpatient Chart Review Checklist is used during this process.

The purposes of the site visits and outpatient clinical chart reviews are:

1. To validate the information provided on the self-assessment tool through site inspection;
2. To review the quality of specialty mental health services provided to beneficiaries, including access to services;
3. To ensure compliance with the LMHP legal agreement, and Medi-Cal documentation requirements;
4. To help identify fraud, waste and abuse issues; and
5. To help identify quality of care issues that need further improvement to better meet the needs of the beneficiaries.

Another part of the clinical chart review is the beneficiary interview. This process may be conducted either telephonic or through survey questions sent to the beneficiaries' addresses. The questions include verification whether services were actually furnished to beneficiaries. This process helps the LMHP in meeting its obligation under Code of Federal Regulations (CFR), Title 42, Section 455.1(a) (2) and the Program Integrity requirement found in the LMHP Contract with DHCS and California Code of Regulations, Title 9, Chapter 11, Section 1810.436.

The Compliance Unit will send a letter informing the providers of the date of the site visit at least three (3) weeks prior to the review. The letter includes copies of Reasons for Recoupment and Outpatient Chart and Review Worksheet. A list of the clinical charts for review will be sent to the provider at least four (4) business days prior to the review. Within two months or as soon as administratively practical, following the site visit, the provider will receive a report summarizing the site visit and clinical chart review findings

Documentation on the clinical record that does not conform to the published county, state and federal rules and regulations will be denied and payment already made will be recouped using the "Reasons for Recoupment". The reason(s) for recoupment and the dollar amount(s) of the denied service date(s) will be identified in the "Line List of Disallowances", which is a part of the review report. When actions are required to correct deficiencies, a request for a Plan of Correction (POC) will be included in the report. The POC is due from the providers within sixty (60) days of the receipt of the written review findings, whether the provider is accessing the appeal process or not. The POC will state how the provider will correct the deficiencies and a timeframe for application to service provisions. A follow-up site visit may be scheduled to confirm implementation of the POC. Further, when egregious clinical, financial and administrative issues are identified during a compliance review, a follow-up review maybe scheduled within six months from the time of the last site visit to ensure that the provider is in compliance with county, state and federal rules and regulations.

Review findings regarding credentialing issues will be referred to the Los Angeles County, Human Resources, Credentialing Unit and will include the issuance of a POC.

The LMHP Compliance Program Office (CPO) also conducts reviews and audits of LMHP programs, providers and contractors. The Health Access and Integration Division (HAI), Compliance Unit may refer cases to the CPO when egregious over utilization of services, suspected fraud or abuse has occurred, or if the findings are beyond the scope or capacity of the Compliance Unit to pursue. The provider should be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code, Section 10115.10.

PROVIDER APPEAL RELATED TO ONSITE REVIEW OF CLINICAL DOCUMENTATION

When a dispute arises from a decision of the HAI, Compliance Unit staff during clinical chart reviews, the provider shall seek resolution following the procedure outlined below based on DMH HAI Division Policy 313.62:

LMHP <u>First Level appeal process</u>

1. If the provider does not agree in whole or in part with the report of review findings, then notification in writing shall be addressed and received by the office of the Mental Health Program Manager III, HAI Division, within 15 calendar days of the provider's receipt of the report. The date that the notification is received by the HAI will be the verification of receipt for the appeal.

   The appeal letter shall include the following:
   a) The appeal shall state the reason(s) for the dispute;
   b) The LMHP's reason for the denial of reimbursement; and
   c) The remedy sought.

   The provider shall include copies of supporting evidence or documentation to refute the LMHP's findings and support the appeal.

2. The Mental Health Program Manager III shall assign the appeal to a clinical person not involved with the clinical chart review.

3. HAI staff shall review and make a decision based on the documentation submitted and the original documents obtained during the chart review. This written decision shall be in writing and sent to the provider within sixty (60) days of the receipt of the appeal. If the appeal is not granted in full, the provider shall be notified of any right to submit a second level appeal.

   <u>Second Level appeal process</u>

1. When resolution is not to the provider's satisfaction, the provider may file a request for a second level appeal. The appeal correspondence shall be directed to the HAI Mental Health Program Manager III. It shall be received within 30 calendar days after the receipt of the first level appeal decision. The letter will be stamped date as verification of LMHP receipt.

   The appeal packet shall include the reason for disagreement along with supporting evidence or documentation to support the appeal and a copy of the first level appeal decision.

2. The appeal will be reviewed by a clinical staff not involved with the chart review or the first level appeal. If the appeal is granted in part, a decision letter signed by the Mental Health Program Manager III will be sent to the provider within thirty (30) calendar days of the receipt. The decision is final.

   If the LMHP does not respond within 60 calendar days to the appeal, the appeal shall be considered denied in full by the LMHP.

   First and second level appeals may be forwarded to the individuals referenced to the contact in the notification letter:

   Name of Current Mental Health Program Manager III
   Mental Health Program Manager III
   Health Access and Integration Division
   510 South Vermont Avenue, 20th Floor
   Los Angeles, CA 90020

REPORTING BENEFICIARY COMPLAINTS

Which Providers Does My MHP Network Provider Use?

MHPs use different types of providers to provide specialty mental health services. These include but are not limited to:

Individual Providers: Mental health professionals, such as doctors, who have contracts with your county's MHP to provide specialty mental health services in an office and/or community setting.

Group Providers: These are groups of mental health professionals who, as a group of professionals, have contracts with your county's MHP to offer specialty mental health services in an office and/or community setting.

As indicated in the *Department of Mental Health Medi-Cal Professional Services Contract* Exhibit A, Section 1.11, the "contractor shall follow established procedures as outlined in the LMHP Provider Manual and Subsequent LMHP Provider Bulletins for beneficiary complaints and shall make records of beneficiary complaints available for authorized review by County and State.

The LMHP's Patients' Rights posters explaining the grievance and appeal processes, together with informing materials, are required to be posted in provider's offices or locations of service. In addition to the posters, informing materials and self-addressed envelopes from the LMHP shall be available to the beneficiaries without the beneficiary having to make a verbal or written request to anyone.