MCCMH MCO Policy 3-001

Chapter: **PROVIDER NETWORK MANAGEMENT**
Title: **AUDIT CONTENT AND TIMETABLE**

Prior Approval Date: 7/30/02
Current Approval Date: 9/6/02

Approved by: _____
Executive Director Date

I. Abstract

This policy establishes the standards and procedures of the Macomb County Community Mental Health Board (MCCMH) for periodic audits and monitoring of critical risk areas to assist in the reduction of identified problem areas in the MCCMH network provider system.

II. Application

This policy shall apply to all directly-operated and contract network providers of the MCCMH Board.

III. Policy

It is the policy of the MCCMH Board to periodically audit and monitor identified critical risk areas within the network provider system to ensure corporate compliance to federal and state laws, regulations and rules; contractual compliance with the MDCH / MCCMH Specialty Service Contract; and effective, efficient, quality administration and provision of services for MCCMH consumers.

IV. Definitions

A. None.

V. Standards

A. See MCCMH Critical Compliance Risk Audit Plan, Exhibit A.

VI. Procedures

A. See MCCMH Critical Compliance Risk Audit Plan, Exhibit A.

VII. References / Legal Authority

A. Pub. L. 104-191

B. MCCMH MCO Policy 1-001, “Overview: Compliance Program / Code of Ethics”

VIII. Exhibit

A. MCCMH Critical Risk Audit Plan, 7/30/02

Macomb County Community Mental Health
Critical Risk Audit Plan

Macomb County Community Mental Health Services has identified seven major areas that are considered "critical risk areas" due to the risk associated with non-compliance in any sector of the MCCMH system. The seven critical risk areas as defined by MCCMH are:

- Verification of Service Billing
- Quality Review of Clinical Services
- Consumer Record Indicators
  - Technical Review of Consumer Records
  - Focused Topic Reviews
- Provider Profile
- Review of Access Center (Medical Necessity) Decisions
- Mental Health Code/Recipient Rights Compliance Audit
- MDCH Key Performance Indicators

MCCMH has developed mechanisms/processes to monitor each of the critical risk areas. Each area is reviewed on a schedule as described below.

Most reviews are conducted utilizing a team approach, drawing on staff from the Policy Management Division, Network Operations, Finance and Budget and Business Management. The exception is the Mental Health Code review conducted by the MCCMH Office of Recipient Rights (ORR), who conducts this review independently.

Universal Precautions Results of all reviews are to be shared throughout the organization. All Divisions and the MCCMH Compliance Office are to receive copies of all audit results, recommendations, plan of correction and periodic status reports regarding the compliance of providers with the audit recommendations. The MCCMH Executive Task Force shall receive quarterly audit report summaries. The MCCMH Board shall receive audit report summaries not less than annually.

Original reports and audit summaries shall be maintained by the MCCMH Executive Director's Office for a time period consistent with MCCMH record retention requirements.

Verification of Service Billing

On an annual basis, MCCMH will review for each provider a selection of claims to 1) verify that services claimed were provided, 2) verify services claimed are listed as covered (or alternative) services in Chapter III of the Medicaid Bulletin, 3) verify that services claimed are identified in the person-centered plan.

Reporting

Audit results will be summarized and analyzed by MCCMH staff according to the following:

- Total number and dollar value of claims processed during the audit period
- Total number and dollar value of the sample
- Number of claims found to be deficient
- Dollar value of claims found to be deficient
- Percentage of claims for which services are listed as covered (or alternative) services in Chapter III of the Medicaid Bulletin
- Percentage of claims for which services are identified in the person-centered plan.

Providers will receive audit results and requirements for Plans of Correction within 60 days following review. Requirements for systematic changes and individual case remediation will be outlined in the Plan of Correction. Also, as part of the Plan of Correction, providers will receive case-specific information with the expectation that individual cases with problems identified are remediated. The MCCMH Business Management Division through the Provider Network Management Unit will be responsible for communicating results to providers and ensuring appropriate Plans of Correction are received and implemented.

Sample Selection

All populations and programs will be audited on an annual basis through a site-based review audit process. A stratified sample of claims for each provider will be tested with a minimum sample of 5% of claims and a minimum of 20 claims for a 12 month period. MCCMH reserves the right to review additional claims records if significant deficiencies are identified in the core sample reviewed.

Remediation

Remediation of audit deficiencies will be conducted in accordance with Appendix G of the MCCMH Corporate Compliance Plan as approved by the MCCMH Board. See Attachment A to this document.

Instrument

Audit results are recorded on a MCCMH-developed form. See Attachment B.

Clinical Quality Review of Consumer Records

On an annual basis, MCCMH reviews consumer records to assess the clinical quality of services being delivered. Critical clinical areas reviewed through this process include:

- Diagnosis/diagnostic formulation is included on Assessment Summary,
- Understandable conclusions regarding consumer's functional capacities, strengths, needs and risks are recorded,
- Diagnoses, functional capacities, strengths, needs, and risks are identified and addressed in the Plan of Service,
- Progress notes and service documentation reflect movement toward Plan of Service goals,
- General review of the record demonstrates that PCP principles are being implemented,
- Services are integrated and coordinated when multiple agents (e.g., primary health care, other CMH

sites/services) are involved,
- Services are coordinated, integrated and monitored (follow-up) when multiple agents (e.g., QHPs, FIA) are involved,
- The use of natural supports is explored and documented. Natural supports are involved, and involvement is documented, where appropriate.

Results will be scored on a Lickert scale (0-4) indicating the degree of clinical quality evident on each item, in each record reviewed.

Reporting

Audit results will be summarized and analyzed by MCCMH staff according to the following:

- Degree of clinical quality by site (site profile)
- Degree of clinical quality by service population
- Degree of clinical quality by level of acuity

Providers will receive audit results and requirements for Plans of Correction within 60 days following review. Requirements for systematic changes and individual case remediation will be outlined in the Plan of Correction. Also, as part of the Plan of Correction, providers will receive case-specific information with the expectation that individual cases with problems identified are remediated. The MCCMH Business Management Division through the Provider Network Management Unit will be responsible for communicating results to providers and ensuring appropriate Plans of Correction are received and implemented.

Sample Selection

All populations and programs will be audited on an annual basis through a site-based review audit process. A sample of cases for each provider will be tested. The Clinical Quality sample will be a proportional subset of cases selected for Technical Review. The appropriate proportion will be established through pilot reviews to be conducted in the Fall of 2002. MCCMH reserves the right to review additional records if significant deficiencies are identified in the core sample reviewed.

Remediation

Remediation of audit deficiencies will be conducted in accordance with Appendix G of the MCCMH Corporate Compliance Plan as approved by the MCCMH Board. See Attachment A to this document.

Instrument

Audit results are recorded on a MCCMH-developed form. See Attachment C.

Technical Review of Consumer Records

On an annual basis, MCCMH will review the consumer charts of a sample of consumers served in the MCCMH provider network. The technical review will focus on non-clinical quality aspects of case record documentation. Elements to be reviewed include:

- General Record Documentation
  - Fee determination
  - Treatment consent
  - Recipient Rights information provided to consumer
  - Grievance and Appeals information provided to consumer
  - Consumer demographic information collected and consistent with information in MIS
- Required Assessments Present
  - Assessment documents level of service provided
  - Discharge planning begun at intake
- Person-Centered Treatment Planning
  - Evidence of pre-planning session
  - Evidence of consumer choice re: location
  - Evidence of consumer choice of participants
  - If case management services are indicated, evidence that consumer was offered a choice of providers
  - Treatment plan review time frames are defined
  - Treatment plan reviews occur as scheduled
  - Service review content
  - Appropriate signatures on treatment plans
- Service Provision
  - Services provided are documented in plan
  - Progress notes contain:
    - Date
    - Begin and end time
    - Service type
    - Progress toward goals
    - Persons present
    - Signature and credentials of staff person
- Care Coordination
  - Documentation of care coordination of clinically significant event(s)
  - Evidence that staff assist consumer in accessing appropriate health care. Need, action taken and follow-up are documented.
  - Evidence that staff follow-up with consumer regarding attendance at appointments, outcome of assessments and recommended follow-up
  - Consents to send and receive information are signed and current
- Medication Management
  - Signed and current Consent for psychotropic medication, including dosage range for all medications prescribed are present
  - Lab results as ordered
  - Evidence of physician review of lab results

Results will be scored on a Lickert scale (0-2) indicating the degree of quality evident on each item, in each record reviewed.

Reporting

Audit results will be summarized and analyzed by MCCMH staff according to the following:

- Degree of technical quality by site (site profile)
- Degree of technical quality by service population

Providers will receive audit results and requirements for Plans of Correction within 60 days following review. Requirements

for systematic changes and individual case remediation will be outlined in the Plan of Correction. Also, as part of the Plan of Correction, providers will receive case-specific information with the expectation that individual cases with problems identified are remediated. The MCCMH Business Management Division through the Provider Network Management Unit will be responsible for communicating results to providers and ensuring appropriate Plans of Correction are received and implemented.

Sample Selection

All populations and programs will be audited on an annual basis through a site-based review audit process. A stratified sample of cases for each provider will be tested with a minimum sample of 5% of cases and a minimum of 20 cases for a 12 month period. For all providers, MCCMH will review a minimum of 350 cases annually. MCCMH reserves the right to review additional records if significant deficiencies are identified in the core sample reviewed.

Remediation

Remediation of audit deficiencies will be conducted in accordance with Appendix G of the MCCMH Corporate Compliance Plan as approved by the MCCMH Board. See Attachment A to this document.

Instrument

Audit results are recorded on a MCCMH-developed form. See Attachment D.

Focused-Topic Review Audits

Periodically, MCCMH will perform focused-topic review audits of direct-operated and contract providers. Focused-topic reviews are conducted based on feedback from external audits/reviews (DCH, CARF, etc.). Topics are generally selected based on remediation needs identified via external audits/reviews. Examples of topics reviewed include: Person-Centered Planning, Completion of Consent Forms and Coordination of Care.

Reporting

Audit results will be summarized and analyzed by MCCMH staff according to the following:

- Degree of compliance by provider site (site profile)
- Degree of compliance by service population

Providers will receive audit results and requirements for Plans of Correction within 60 days following review. Requirements for systematic changes and individual case remediation will be outlined in the Plan of Correction. Also, as part of the Plan of Correction, providers will receive case-specific information with the expectation that individual cases with problems identified are remediated. The MCCMH Policy Management Division will be responsible for communicating results to providers and ensuring appropriate Plans of Correction are received and implemented.

Sample Selection

Samples for focused-topic reviews are selected on a random basis. Sample size is relatively small in order to allow for frequent reviews of a variety of pertinent topics.

Remediation

Remediation of audit deficiencies will be conducted in accordance with Appendix G of the MCCMH Corporate Compliance Plan as approved by the MCCMH Board. See Attachment A to this document.

Instrument

Audit results are recorded on a MCCMH-developed form. Due to the nature of this review, topics and data collection forms are subject to periodic change. As a result, a sample instrument is not included with this Plan.

Provider Profile

Contract providers seeking to participate in MCCMH's provider network must complete a Provider Profile Application. The application contains the following information about the provider and qualifications to participate in the MCCMH provider network:

- Copy of any licenses, certificates and/or registrations required for the type of facility for which the applicant is seeking approval
- The provider's Code of Ethics
- Facility history containing a statement by the provider detailing the provider's professional liability claims history
- Provider's demonstrated ability to manage financial obligations
- Provider statement regarding any loss of licensure or certification, any history of loss or limitations or any disciplinary action against the facility or its service providers by the State or any other regulatory body as well as any Medicare/Medicaid sanctions
- Provider's staffing pattern
- Documentation of current JCAHO, CARF, COA or other accreditation or evidence that appropriate accreditation is in process
- Other additional documentation as required pertinent to services to be provided.

Every two years, at the point of contract renewal for all contractors, MCCMH will review provider records for the purpose of verification of the information submitted on the Provider Profile (see detail above). Audit elements will be scored on a "yes" or "no" basis, indicating that the provider is, or is not, in compliance with the audit element(s). Audit staff may alternatively indicate that the element does not apply to the provider.

As part of the RFP/contractor review process for new contract providers, MCCMH requires satisfactory completion of a provider application and RFP package. MCCMH routinely seeks review/input from consumers as part of the provider selection process.

Reporting

Audit results will be summarized and analyzed by MCCMH staff according to the following:

- Degree of compliance with application/certification requirements by provider
- Degree of compliance with application/certification requirements for the overall MCCMH Provider Network

Providers will receive audit results and requirements for Plans of Correction within 60 days following review. The MCCMH Business Management Division through the Provider Network Management Unit will be responsible for communicating results to providers and ensuring appropriate Plans of Correction are received and implemented. Results will be taken into

consideration at the time of contract renewal or expansion. In the event that a provider is found to be out of compliance, e.g., required license has been suspended or revoked, MCCMH reserves the right to suspend or terminate the provider contract until appropriate remediation steps have been completed to the satisfaction of MCCMH.

Sample Selection

All providers in the MCCMH Provider Network will be subject to annual review of contract requirements detailed herein.

Remediation

Remediation processes and outcomes are governed by the contract between MCCMH and the Provider.

Instrument

Audit results are recorded on a MCCMH-developed form. See Attachment E.

Review of Medical Necessity - Access Center Decisions

MCCMH reviews Access Center decisions made around critical services on an ongoing basis to ensure that decisions made are clinically appropriate and that services authorized are medically necessary. The following reviews are conducted on the schedule indicated.

- Children's Access to Care/ Weekly Review & Monthly Report
- Inpatient Episodes/ Monthly Review & Report
- Long Term Inpatient Episodes/Monthly and/or Quarterly Review & Report
- Initial Assessment Resulting in Potential Change in Level of Care or Service Denial for Non-Emergent Services/Monthly Report

Children's Access to Care

On a weekly basis, all decisions to deny initial requests for assessment for children's services by Access Managers are reviewed by an Access Center supervisor (minimally a Master's prepared clinician). The supervisory review of the service request is via the MCCMH MCO computerized record. Decisions are reviewed for thoroughness and clinical appropriateness on "Children Not Given Appointment Log" (See Attachment F).

Reporting

Through the review process itself, MCCMH Access Center supervisory staff become aware of any inappropriate decisions.

Review data is aggregated monthly and a report is generated from the Access Center regarding all requests for services for which an initial assessment was not scheduled, including:

- Total number
- Number and percentage of requests where supervisory review determined the initial decision was appropriate
- Number and percentage of requests where supervisory review determined follow-up was needed
- Number and percentage of requests which received an appointment for assessment following

supervisory review.

The MCCMH Access Center will provide a monthly report to the Compliance Office regarding decisions about initial assessments for children.

Sample Selection

100% of requests for services for children where an initial assessment is not scheduled are selected for review.

Remediation

Access Center supervisory staff will complete a “Request for Children’s Services Access Center Review of Initial Decision” (Attachment G) form for each case where supervisory review determined that additional follow up was needed to ascertain appropriateness of initial decision.

This supervisor will complete the initial part of the form with case specific identifying information and give the form to the Access Manager who took the initial call. A client care coordinator may also be assigned, and will be given a copy of the form.

If a client care coordinator is assigned, the client care coordinator will contact the parent/guardian within 24 hours of receipt of the case assignment to determine the current desire of the parent/guardian to receive services from MCCMH, and/or to identify alternative services the parent/guardian may have sought. The client care coordinator will update “Actions Taken” in the CMHC system, complete the form and return it to the supervisor.

If the case is referred to the Access Manager, without Client Care Coordinator involvement, the Access Manager will contact the parent/guardian and offer an appointment for an initial assessment. The Access Manager will update “Actions Taken” in the CMHC system, complete the form and return it to the supervisor.

In any case where the initial determination was not supported, the issue surrounding the request will be used for training to increase the skill of the Access Managers so that similar errors are prevented in the future. Regular monthly staff meetings, as well as ad hoc meetings, will provide the venue for this education and corrective action.

Remediation action, including Plans of Correction, if any, and training provided are included as part of the regular quarterly report to the MCCMH compliance officer.

Instrument

Audit results are reported on an MCCMH-developed form. (Attachment H)

Inpatient Episodes

On a monthly basis, the MCCMH contracted consulting psychiatrist (hereafter "psychiatrist") will review inpatient acute care episodes for children, adolescents, and adults. The MCCMH psychiatrist will complete an "Inpatient Sample Review Worksheet" (Attachment I) assuring that the admission and continued stay reviews are medically necessary and clinically appropriate for each episode reviewed.

Reporting

The MCCMH Access Center staff will prepare a summary of the total cases reviewed for each month including the following information:

- Total number of cases reviewed
- Number of cases found to be clinically appropriate and medically necessary
- Number of cases found not to be clinically appropriate and medically necessary

Sample Selection

Each month a 10% random sample representing acute care inpatient episodes with discharge dates in the prior month will be selected from all contracted hospitals. Cases representing service populations of child, adolescent, and adult inpatient episodes will be reviewed.

Remediation

In cases where the admission is deemed inappropriate by the MCCMH psychiatrist, Access Center supervisory staff will review the case with the authorizing Access Manager to educate the Access Manager concerning the reason the decision was deemed inappropriate.

Regular staff meetings will afford the opportunity for Access Center supervisory staff to present information to the entire staff relative to any general issues which need clarification regarding medically necessary and appropriate admissions.

Remediation action, including Plans of Correction, if any, and training provided is included in the regular quarterly report.

Instrument

Audit records are recorded on an MCCMH-developed form. (Attachment J)

Long Term Inpatient Care

On a case by case basis, the MCCMH Access Center psychiatrist will review referrals for long term inpatient care admissions for adults to assure clinical appropriateness of the admission and that a consumer is not inappropriately denied access to this service. An MCCMH Access Center master's prepared clinician will review continued stays for all consumers in long term inpatient care on a quarterly basis.

On a case by case basis, the MCCMH psychiatrist will review the Access Center Clinical Packet of information/documentation for referrals to Long Term Inpatient care. The psychiatrist may request additional information, or make a determination to accept the consumer as appropriate for Long Term Inpatient care, or determine that the consumer is inappropriate for admission to Long Term Inpatient care. The decision is documented on the referral form. The MCCMH

psychiatrist will complete the "Long Term Inpatient Referral/Cover Sheet" assuring that the admission is medically necessary and clinically appropriate for each case reviewed (Attachment K).

Reporting

Referrals packets are maintained at the Access Center and a monthly report is generated detailing the raw number and percentage of referrals which were accepted as appropriate to Long Term Inpatient care and the percentage and number of cases which were determined to be inappropriate for admission to Long Term Inpatient care.

The MCCMH staff will prepare a summary of the total cases reviewed for each month. The summary will include the following information:

- Total number of cases referred
- Number of cases found to be clinically appropriate and medically necessary for admission
- Number of cases found not to be clinically appropriate and medically necessary for admission

The MCCMH Access Center will provide a quarterly report to the Compliance Office regarding Access Center decisions related to Long-Term Inpatient Care admissions.

Sample Selection

100% of adult referrals for Long Term Inpatient care will be reviewed within 48 hours of completion of the referral form and assembly of the clinical packet by the designated Access Center Access Manager and delivery to the MCCMH psychiatrist.

Remediation

In cases where the referral is deemed inappropriate for admission to long term inpatient care by the MCCMH psychiatrist, the case will be reviewed with the referring Access Manager to educate the Access Manager concerning the reason the case was denied. The Access Manager will have opportunity to present additional information which may not have been in the original referral if this information will clinically change the case and support a reversal of the denial.

Remediation action, including Plans of Correction, if any, and training provided is included as part of the regular quarterly report to the MCCMH Compliance Office.

Instrument

Audit results are recorded on a MCCMH-developed form (Attachment L).

Initial Assessment Resulting in Potential Change in Level of Care or Service Denial for Non-Emergent Macomb County CMH Services

Consumer or provider requests for consumer entry into non-emergent MCCMH services are scheduled for initial assessment at a provider site following the Access Manager's determination of consumer's apparent eligibility for services, medical necessity, consumer choice, and service selection guidelines.

Potential Change in Level of Care or Service Denial
In cases where it is the opinion of the service provider, following the initial face-to-face assessment of the consumer, that

the consumer does not meet eligibility criteria for services at the level of care which can be obtained through that provider, the provider will notify the Access Center by faxing the completed core assessment packet to the Access Center. If it appears that the consumer meets eligibility criteria for services at an alternative level of care the following steps will be followed: An Access Center "Withdrawal/Diversion/Denial for Service Following Initial Assessment" (Attachment M) is attached to the packet as a cover sheet to aid in tracking.

- The Access Manager who processed the initial request will review the core assessment packet
- The Access Manager will attempt to contact the consumer/guardian to obtain their point of view relative to the assessment and their current desire for treatment
- If the Access Manager agrees with the provider's assessment that the original provider cannot meet the consumer's service needs, but the consumer has needs which can be met by another MCCMH provider, the Access Manager will assist in transfer of the consumer's care to the appropriate provider. The provider who conducted the initial assessment will retain responsibility to provide support and medically necessary services to the consumer while the transfer is in process. The Access Manager will update the CMHC system.
- If the Access Manager disagrees with the provider's assessment and believes that the consumer does have needs which are most appropriately met by that provider, the Access Manager will contact the clinician who performed the initial assessment and attempt to negotiate an agreement with that clinician. This may include obtaining additional information. If the Access Manager and the clinician come to an agreement that the consumer can be served by that provider, ongoing services will be authorized. If the Access Manager and the clinician agree that the consumer is better served by another provider/level of care the Access Manager will assist with the transfer (See above). The Access Manager will update the CMHC system.
- If, despite the exchange of information, and good faith negotiation, the Access Manager and the clinician cannot agree on the appropriate disposition of the case, the Access Manager will forward the core assessment packet and all additional information that has been obtained to the Access Center Supervisor, or designee. The Access Manager will update the CMHC system.
- Access Center supervisory staff will review the information and contact the provider supervisory staff, if necessary, to obtain agreement on service provision, if this appears warranted. If agreement to provide services is obtained, Access Center supervisory staff will return the packet to the Access Manager to authorize services. If Access Center supervisory staff and provider supervisory staff do not agree, the case will be referred to the Area Manager. Access Center supervisory staff will update the CMHC system to reflect this action.
- If, following the review, Access Center supervisory staff agrees with the decision of the service provider following the initial assessment, that the consumer's needs cannot be met by services in the array provided by MCCMH, Access Center will provide the consumer with appropriate notification of their right to a second opinion and will notify the Director of Business Management and the Director of Behavior Health of the outcome of the request for services (Attachment N or O depending on medical status).

Reporting

On a quarterly basis, the Access Center will generate a summary report which details the following:

- Total number of cases reviewed
- Number of cases in which the original Access Center decision was upheld
- Number of cases in which the original Access Center decision was overturned
- Summary by provider of number of cases inappropriately returned to Access Center following

assessment

The MCCMH Access Center will provide a quarterly report to the Compliance Office regarding Access Center decisions related to inpatient episodes.

Sample Selection

100% of cases in which the service provider, following initial face-to-face assessment, believes that the consumer does not meet eligibility criteria for services at the level of care available through the provider are reviewed.

Remediation

In the event that Access Center inaccurate decision-making regarding referral to providers exceeds 10%, additional training will be provided to Access Center staff involved in the decision-making/referral process.

In the event that a provider inappropriately returns cases at a level that exceeds 10%, action will be taken in accordance with the provider contract or service assurance agreement.

Instrument

Audit results are recorded on a MCCMH developed form. (Attachment P)

Mental Health Code Audit - Recipient Rights

On an annual basis, the MCCMH Office of Recipient Rights (ORR), conducts a review of each provider to ensure compliance with the Recipient Rights elements of the Michigan Mental Health Code (Chapter 7 and 7A; Sec. 330.1753, Recipient Rights System; Review by Department). MCCMH MCO Policy 9-135 guides the monitoring/review process.

The review is conducted at all directly operated and contracted facilities, including group homes, workshops and clinics. Individualized assessment tools are utilized for different treatment settings. The review is intended to examine the recipient rights policies of each facility and to ensure consumer rights are protected.

The review includes the following elements:

- Environment (overall condition, barrier-free accessibility, cleanliness and safety areas of the facility)
- Fire Safety (reviewing emergency drills such as tornado, fire, etc.)
- Rights Protection (notification of recipient rights, supply of posters and rights booklets)
- Use of restraints, (staff training to insure safety of consumers, etc.)
- Personal Property & Funds (expenditure of personal money, sufficient clothing, available storage space, etc.)
- Communications (accessibility of telephones, visiting hours, restrictions regarding reading/viewing/listening materials, etc.)
- Recipient Labor, (labor compensation)
- Religious Worship, (access to religious worship)

- Voting Rights
- Facility Vehicle (facility vehicle maintenance, etc.)
- Confidentiality, Fingerprinting, Photographs & Audio tapes (safekeeping consumer documentation, release of information & image consents)
- Medical, Health & Menus (consent for psychotropic medications, side effects of meds, first aid supplies, menus and therapeutic diets)
- Recipient Record (a current IPOS which is updated annually, use of PCP)

Reporting

Copies of the completed assessment tool are provided to the provider following the completion of the review. The completed assessment tool documents the findings (Full Compliance, Partial Compliance, Non-Compliance, Not Applicable) of the review on each element.

Results of completed monitoring assessments are presented to the MCCMH Recipient Rights Advisory Committee on a quarterly basis. In addition, the results of completed monitoring assessments are presented to the MCCMH Quality Assessment and Improvement Committee.

Sample Selection

Direct service units and contract service agencies provide five open cases for ORR review. Cases are randomly selected by ORR on the day of the review. MCCMH reserves the right to review additional case records if significant deficiencies are identified in the core sample reviewed.

Remediation

In the event that Recipient Rights deficiencies are identified during the course of the review, the agency/contractor shall develop and submit a Plan of Correction within 15 business days. The MCCMH Office of Recipient Rights is responsible for communicating results to providers and ensuring appropriate Plans of Correction are received and implemented.

Instrument

Audit results are recorded on a MCCMH-developed form. See the following attachments:

- Residential Setting - Attachment Q
- Clinic Setting - Attachment R
- Workshop Setting - Attachment S

Review of MDCH Key Performance Indicators

On an ongoing basis, MCCMH will monitor its performance on MDCH Key Performance Indicators. Monitoring will occur on multiple levels including through the MCCMH Executive Staff, Quality Improvement Council, Compliance Office, and Network Operations.

Plan Revision

MCCMH's Critical Risk Audit Plan will be reviewed by MCCMH on annual basis and updated/revised as necessary.

Macomb County Community Mental Health
Critical Risk Compliance Audits

Audit Area	Review Frequency (each provider)	Report Frequency	Sample Size	Applies To:	Start Date	Lead for Review Area:
Verification of Service Billing	Annual	Annually to Divisions & Compliance Office, Annually to CMH Board	Minimum of 5% of claims, minimum of 20 claims over 12 month period per provider.	All Providers	Fourth Quarter, 2002	Finance and Budget and Business Management(Jefferson Wells)
Clinical Quality Review of Consumer Records	Annual	Quarterly to Divisions & Compliance Office, Annually to CMH Board	Proportional subset of cases selected for Technical Review. The appropriate proportion will be established through pilot reviews to be conducted in the Fall of 2002.	All Providers	Fourth Quarter, 2002	Network Operations
Technical Review of Consumer Records	Annual	Quarterly to Divisions & Compliance Office, Annually to CMH Board	Minimum of 5% of cases, minimum of 20 cases over 12 month period per provider.	All Providers	Fourth Quarter, 2002	Policy Management(Jefferson Wells)
Focused-Topic Reviews	Variable	Variable	3 - 5 records per reporting unit/service.	Variable	Currently in Place	Policy Management

Macomb County Community Mental Health
Critical Risk Compliance Audits

Audit Area	Review Frequency (each provider)	Report Frequency	Sample Size	Applies To:	Start Date	Lead for Review Area:
Provider Profile	Annual	Quarterly to Divisions & Compliance Office, Annually to CMH Board	All Providers	All Providers	Fourth Quarter, 2002	Business Management
Review of Medical Necessity - Access Center Decisions, Children's Access to Care	Case-by-Case - Ongoing	Quarterly to Divisions & Compliance Office, Annually to CMH Board	100% of requests for services for children where an assessment is not scheduled	Access Center	Currently in Place	Business Management
Review of Medical Necessity - Access Center Decisions, Inpatient Episodes	Case-by-Case - Ongoing	Quarterly to Divisions & Compliance Office, Annually to CMH Board	10% random sample representing acute care inpatient episodes in the prior month from all contracted hospitals	Access Center	Fourth Quarter, 2002	Business Management
Review of Medical Necessity - Access Center Decisions, Long-term Inpatient Care	Case-by-Case - Ongoing	Quarterly to Divisions & Compliance Office, Annually to CMH Board	100% of adult referrals for sub-acute care	Access Center	Currently in Place	Business Management

Macomb County Community Mental Health
Critical Risk Compliance Audits

Audit Area	Review Frequency (each provider)	Report Frequency	Sample Size	Applies To:	Start Date	Lead for Review Area:
Denial of Services Decision by Service Site (based on assessment)	Case-by-Case - Ongoing	Quarterly to Divisions & Compliance Office, Annually to CMH Board	All cases referred by Access Center to Service sites that are denied service are reviewed	All Providers	Currently in Place	Business Management
Mental Health Code Audit (ORR)	Annual	Quarterly to Divisions & Compliance Office, Annually to CMH Board	Minimum 5 open cases per provider	All Providers	Currently in Place	Office of Recipient Rights
Key Performance Indicators	Ongoing	Quarterly to Divisions & Compliance Office, Annually to CMH Board	Review of all MDCH Key Performance Indicators	All Providers	Currently in Place	Policy Management Division

Macomb County Community Mental Health
Critical Risk Audit Plan
Attachment List

Attachments Available through the MCCMH Corporate Compliance Office

- Attachment A - MCCMH Corporate Compliance Plan, Appendix G - Audit Content and Timetable Policy, Audit Follow-up Policy
- Attachment B - Verification of Service Billing Audit Form
- Attachment C - Quality Record Review Form
- Attachment D - Technical Record Review Form
- Attachment E - Program Application (Provider Profile) Audit checklist
- Attachment F - Children Not Given Appointment Log
- Attachment G - Request for Children's Services - Access Center Review of Initial Decision
- Attachment H - Monthly Summary of Children Not Given Initial Assessment Appointment Form
- Attachment I - Inpatient Sample Review Worksheet
- Attachment J - Inpatient Review Monthly Summary Form
- Attachment K - Long Term Inpatient Referral/Cover Sheet
- Attachment L - Monthly Summary of Referrals to Long Term Inpatient Care
- Attachment M - Withdrawal/Diversion/Denial for Service Following Initial Assessment Form
- Attachment N - Adequate Action Notice
- Attachment O - Inpatient Service Denial Letter
- Attachment P - Withdrawal/Diversion/Denial for Service Following Initial Assessment - Quarterly Report
- Attachment Q - Office of Recipient Rights - Annual Site Assessment, Residential Setting
- Attachment R - Office of Recipient Rights - Annual Site Assessment, Clinic Setting
- Attachment S - Office of Recipient Rights - Annual Site Assessment, Workshop Setting