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Preface

In July 2005, the New Mexico Human Services Department (NM HSD), as well as multiple state agencies, implemented the first phase of its Behavioral Healthcare System Transformation. This restructuring created one Statewide Entity (SE) to coordinate behavioral health (BH) services across multiple state funding streams for publicly funded programs. A contract was awarded to ValueOptions of New Mexico (ValueOptions) as the SE. Included in the transformation to a single statewide BH system, ValueOptions partnered with the state’s Behavioral Health Purchasing Collaborative in managing the NM publicly funded BH service system.

Required by the SE vendor agreement, ValueOptions must comply with the NM Administrative Code (NMAC), in particular, NMAC 8.305, which contains the regulations governing the BH program. These standards are designed to ensure BH care services provided to managed care Medicaid consumers are consistent with professionally recognized standards of care, as well as the NM Medicaid managed care regulations.

The NM HSD has contracted with New Mexico Medical Review Association (NMMRA) to conduct monitoring, auditing, surveying and assessment activities necessary to provide NM HSD with valid and reliable information and data about the performance of the contracted SE for BH services, as its performance relates to access to and quality of care provided to Medicaid consumers in the state. NM HSD issued Letter of Direction (LOD) No. 07-09 on December 15, 2006 to NMMRA to conduct an audit of ValueOptions’ administrative and clinical denials, as well as terminations and reductions of care for the first quarter of fiscal year 2007 (July 1, 2006 through September 30, 2006). The scope of work addresses all appropriate Medical Assistance Division (MAD) regulations, as well as NMMRA’s findings and recommendations from the fiscal year (FY) 2006 utilization review audits completed by NMMRA. This audit represents ValueOptions’ third Utilization Review (UR) Denial Audit conducted by New Mexico Medical Review (NMMRA).

Audit Approach and Methodology

The audit approach and methodology were designed to align the audit process with the SE’s contractual requirements with NM HSD and the LOD specifications defined by NM HSD. NMMRA used data collection and data analysis procedures to provide audit assurance and to identify areas requiring further investigation. The methodology (as well as the scoring methodology), was designed according to the NMAC 8.305.8.13 Utilization Management Regulations.

NMMRA was directed by NM HSD to specifically include the following points in the audit scope of work:

- Identification of expedited appeals for urgent request
- Notification to the consumer and provider when an expedited appeal has occurred
• Use of the clinical denial letter template
• Use of the administrative denial letter template
• Medical director documentation for clinical denials
• Clinical information included in documentation
• Citation of MAD regulation for all cases
• Thorough case file documentation

The scoring methodology was developed using NMAC, NM MAD regulations and the Centers for Medicare & Medicaid Services (CMS) protocol for assessing a managed care organization’s performance. The final methodology consisted of the following sections:
• rationale (understanding of the regulations and LOD specifications)
• evidence required (documentation and case review)
• interpretive guidelines
• data collections tools
• scoring criteria

The universe for the audit contained all recorded denials of BH services, excluding pharmacy and transportation services, for Medicaid consumers during the audit period as reported in Report 65/HSD 2 by ValueOptions to NM HDS. The audit sample was designed to be:
• Representative of the population eligible for Medicaid BH services, by demographic characteristics, geographic distribution, and enrollment
• Representative of the range of BH services provided under the state’s Medicaid program
• Representative of the eligible providers serving the NM Medicaid population
• Representative of the types of situations in which ValueOptions appropriately may deny BH services
• Representative of the setting types of services; outpatient care, treatment foster care (TFC), residential treatment center (RTC) and inpatient psychiatric hospital
• Of a size large enough to develop statistically sound conclusions without placing undue burden on the entity being audited

The sample was defined by:
• Thoroughly reviewing the universe data supplied by ValueOptions to identify any patterns in the aggregate data which would suggest a need for targeted, non-random sampling
• Determining the appropriate sample sizes of each subset of the universe, and applying randomization techniques to select the samples to be audited on-site
  • Using a random number sequence and random selection process:
    • The medical record universe was sorted by strata (administration versus clinical denials)

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1 Report 65/HSD 2 is a detailed denial of services report that includes specifics related to all denied services.
Once the strata were separated, a random number was assigned to each medical record using an Excel® random number generator function.

- The medical records were then sorted in descending order by the random number that Excel® assigned.

- The final sample was determined by the order of the sort - first 40 records.

Based on the universe provided and in consideration of the tasks listed above, it was determined that 30 cases were required for the audit sample. To ensure that a full 30 cases would be audited, ten additional cases were added as a “control risk” to prevent a sampling error, such as non-managed care payor type or date of service errors within the data universe provided.

**Audit Guide and Tool**

The Behavioral Health Utilization Review Denial Audit Guide and Tool were developed using NMAC and NM MAD regulations 8.305.8.13. These materials specifically include the MAD regulations related to the LOD requirements for the audit. The audit tool was tested to ensure accuracy, ease of use and consistency, and approved by NM HSD prior to implementation. NMMRA sponsored a workshop for ValueOptions on the audit guide and tool in advance of the audit to ensure familiarity with NMMRA’s audit scope and processes to conduct the audit. Revisions were completed to adjust for the recommendations made during the workshop.

**Audit Overview**

Approximately two weeks prior to the scheduled audit, NMMRA conducted a teleconference with representatives from ValueOptions. The teleconference provided an opportunity to review applicable rules, regulations, quality standards, documentation and information to be sent in advance, preview the audit tool, and the audit timeline and duration. Suggestions as to what are important areas or possible risk areas were solicited. NMMRA’s response to the conference was to finalize the audit based on responses shared, which resulted in minor revisions to the scoring methodology.

**On-Site Meeting**

NMMRA conducted an opening conference with key personnel from ValueOptions. The purpose of the opening conference was to introduce the audit team, distribute and discuss the audit goals, describe the audit process, describe the nature and scope of the audit, identify the timetable for completion of the audit and explain the role of the NMMRA External Quality Review Organization (EQRO) medical director in relation to potential quality of care cases, suspected fraud and abuse cases and second-level review. ValueOptions received an introductory packet, including a detailed site-visit agenda. Following NMAC Standards, NMMRA’s Behavioral Health Utilization Review Denial Audit Guide and Tool, NMMRA examiners collected detailed information assessing ValueOptions’ compliance with the defined standards.
The on-site visit lasted one day and was conducted by three NMMRA EQRO examiners. EQRO examiners reviewed all cases in the sample and reviewed ValueOptions’ utilization management (UM) and administrative policies and procedures governing denials. This included criteria for the use of qualified professionals, use of clinical information and timeliness standards.

NMMRA reviewed 24 UM clinical denial cases and six administrative denial cases to assess compliance with applicable MAD standards, citation of the MAD medical necessity definition and correct application of level-of-care criteria. The cases selected represented a range of BH services, including urgent, non-urgent and concurrent case review, and included denial cases involving individuals with special health care needs (ISHCN). Case review files that did not score 100% were discussed on-site with ValueOptions’ utilization management staff to ensure all documentation was made available to NMMRA reviewers, and NMMRA reviewers interviewed ValueOptions staff to obtain clarification on incomplete cases.

At the conclusion of the on-site visit, a closing conference was conducted by NMMRA and attended by ValueOptions and NM HSD. NMMRA presented its preliminary findings, provided feedback, and answered questions. At NMMRA’s request, the ValueOptions attendees completed an event evaluation. The evaluation was based on a five-point scale, with five being the highest and one being the lowest approval rating. An aggregate average of 4.85 was scored, indicating high satisfaction with the audit engagement. Attendees were “highly satisfied” with the audit overview process and documentation provided by NMMRA.

**Scoring Methodology**

Data provided by ValueOptions, either prior to or during the on-site audit, was the only information considered by NMMRA in determining ValueOptions’ compliance with NMAC regulations. NMMRA’s findings formed the basis for assigning preliminary and final ratings on the defined standards and measures.

**Overall Indicators**

In assessing the ValueOptions’ performance, NMMRA addressed the following indicators in addition to scoring case-level performance:

- Assessment of consistent applications of the ValueOptions’ clinical criteria in denial decisions based on MAD approved definitions
- Assessment of consistent application of the NM Medicaid medical necessity definition in MAD regulation 8.305.1.7 M (8) definition
- Patterns of utilization denials, such as unusual trends in denials by procedure and diagnosis, based on existing baseline data
- Aggregating the sums of individual case scores and calculations of the overall compliance percent score

**Case Review Scoring**

Each case in the sample was evaluated using the Behavioral Health Utilization Review Denial Audit Tool. A numerical score of 1 or 0 was assigned to each standard element as noted in Table 1.
Table 1:

<table>
<thead>
<tr>
<th>Standard Element</th>
<th>Case Review Scoring</th>
<th>Types of Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-certification</td>
<td>Pre-certification</td>
</tr>
<tr>
<td></td>
<td>(Routine)</td>
<td>(Urgent)</td>
</tr>
<tr>
<td>Request Type Timeliness</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Case Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Review</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Denial Rationale</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Criteria</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Relevant Clinical Information</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Denial Letter Notification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denial Reason</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Criteria Referenced</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Copy of Criteria Available</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Reviewer Availability</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Appeal Rights</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Notification Timeliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Consumer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Expedited Appeal (Urgent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Consumer</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Expedited Appeal (Concurrent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Consumer</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>14</td>
</tr>
</tbody>
</table>

**Compliance Levels**

Individual case scores were summarized and aggregated, and then a percent overall score was determined and interpreted as described in Table 2.
Table 2: SE Compliance Levels

<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Percentage Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90% - 100%</td>
<td>SE has met or exceeded standard</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>79% - 89%</td>
<td>SE has met most requirements of the standard, but may be deficient in a small number of measures</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>60% - 78%</td>
<td>SE has met some requirements of the standard, but has significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>&lt; 60%</td>
<td>SE has not met requirements of the standard, mandatory corrective action</td>
</tr>
</tbody>
</table>

NMMRA examined the scores within each measurement criterion above to determine if there were patterns of performance deficiency where recommendations for quality improvement activities would be appropriate.

**EQRO Agreement Rate on Denial Decisions**

Each case in the sample was reviewed by NMMRA to determine an overall Agreement Rate on Denial Decisions. The rate was calculated and interpreted as described in Table 3:

Table 3: Agreement Rate on Denial Decisions

<table>
<thead>
<tr>
<th>Decision Classification</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior</td>
<td>85% - 100%</td>
</tr>
<tr>
<td>Opportunity for improvement and recommendations provided</td>
<td>70% - 84%</td>
</tr>
<tr>
<td>Mandatory corrective actions and follow-up documentation required by SE</td>
<td>Less than 70%</td>
</tr>
</tbody>
</table>

- Potential Quality of Care Recommendations only – no corrective action
- Suspected Fraud & Abuse Recommendations only – no corrective action

**Inter-Rater Reliability (IRR)/Data Validation**

Examiner inter-rater reliability was maintained through the assignment of audit responsibility to the primary NMMRA reviewer, the use of standardized data collection tools, the use of common audit resources, ongoing communication, and coordination among the audit team. Prior to initiating the IRR process, the primary reviewer developed a descriptive tool which provides specific instructions on how to complete the review. NMMRA’s EQRO program director reviewed and approved the audit tools and scoring tables to ensure consistency across NMMRA reviewers, and internal logic and reasonability. The primary NMMRA reviewer also conducted peer review of each section to ensure consistency in assigning designation, scoring and language.
An IRR assessment was conducted on 10 cases or 33% of the sample. This percentage exceeds NMMRA’s standard of 20 percent to ensure reliability and validity. The higher percentage rate was determined to ensure reliability in the audit tool completion and to validate the correct denial determination. The NMMRA EQRO program director, in advance of final data analyses, reviewed potential discrepancies between NMMRA reviewers and findings were reviewed with NMMRA EQRO staff for training purposes.

Findings
Table 4 presents the final score for Case Review and EQRO Agreement Rate, and a comparison from prior audits. As described in the Scoring Methodology section of this report, the final overall scores were calculated by:

- Assigning a numeric score to each element in the performance criteria
- Aggregating the sums of individual case scores and calculates a percent overall score
- Assigning a level of compliance designation based upon the percent overall using the following approved scale:
  
<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90 – 100%</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>79 – 89%</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>60% - 78%</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>below 60%</td>
</tr>
</tbody>
</table>

- The EQRO Agreement Rate was calculated and assigned using the following designations:
  
<table>
<thead>
<tr>
<th>Agreement Rate</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior</td>
<td>85 - 100%</td>
</tr>
<tr>
<td>Opportunity for Improvement</td>
<td>70 – 84%</td>
</tr>
<tr>
<td>Mandatory corrective action</td>
<td>70% and below</td>
</tr>
</tbody>
</table>

Table 4:

<table>
<thead>
<tr>
<th>Review Period</th>
<th>FY 07 1st Qtr</th>
<th>FY 06 3rd Qtr</th>
<th>FY 06 2nd Qtr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Score</td>
<td>Score</td>
</tr>
<tr>
<td>Case Review Points</td>
<td>367 out of 370</td>
<td>99%</td>
<td>84%</td>
</tr>
<tr>
<td>EQRO/SE Agreement</td>
<td>6 out of 6</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>19 out of 24</td>
<td>79%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Case Review
ValueOptions scored 367 points out of a possible 370 points, and earned a rating of Full Compliance in Case Review. ValueOptions has made notable improvements in its written policies and procedures and case documentation from previous audits.
ValueOptions scored 100% in all measured areas, except for the three areas listed below. It is important to note the ValueOptions scored better than 90% across all areas. The Summary Scores by Section and Detail Scores Report is included in Appendix 1 and Appendix 2.

- Physician Review (D2) 92%
- Case Documentation – Criteria (B3) 97%
- Case Documentation – Relevant Clinical Information (F3) 92%

**Agreement Rate on Denial Decisions**

NMMRA audited six cases for administrative review. ValueOptions scored 100% in the Agreement Rate on Denial Decisions for Administrative Review and earned a rating of **Superior** for this measure.

NMMRA audited 24 cases for Clinical Review. ValueOptions scored 79% in the Agreement Rate on Denial Decisions for Clinical Review and earned a rating of **Opportunity for Improvement** for this measure. Six of the clinical review cases were sent by NMMRA to second-level review due to NMMRA’s disagreement with ValueOptions’ denial decisions. Five of the second-level review cases in which NMMRA disagreed with ValueOptions’ denials were upheld by the second-level reviewer(s). Three of the five cases were residential treatment center (RTC) pre-certification requests where ValueOptions did not follow its HSD approved level-of-care guidelines. Similarly, the two remaining cases, an inpatient concurrent stay request and a Treatment Foster Care (TFC) pre-certification request, were also upheld because ValueOptions did not follow its HSD approved level-of-care guidelines. The EQRO Disagreement with SE Denial Decision and Insufficient Information to Support SE Denial Decision reports are included in Appendix 3 and Appendix 4.

The completed audit tools for the cases that NMMRA disagreed with ValueOptions’ denial decisions are included in Appendix 5.

**Other LOD Elements**

Table 5 presents the other LOD elements reviewed within the audit scope. This includes the total number of potential quality of care cases, suspected fraud and abuse cases, and misclassified denials. The misclassified denial results were derived from the total number of denials classified within the administrative, clinical, reduction of care and termination of care categories. A report of the misclassified denials is found in Appendix 6.

<table>
<thead>
<tr>
<th>Type of Case</th>
<th>Case Review Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud and Abuse</td>
<td>No findings</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>No findings</td>
</tr>
<tr>
<td>Misclassified Denials</td>
<td>#</td>
</tr>
<tr>
<td>Administrative</td>
<td>0/6</td>
</tr>
<tr>
<td>Clinical</td>
<td>1/9</td>
</tr>
<tr>
<td>Reduction of Care</td>
<td>None</td>
</tr>
<tr>
<td>Termination of Care</td>
<td>0/15</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1/30</td>
</tr>
<tr>
<td>% Correct</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>97%</td>
</tr>
</tbody>
</table>
No suspected fraud and abuse, or potential quality of care cases were identified. One clinical denial was misclassified as an administrative denial based on ValueOptions’ policy and procedure.

**Noted Improvement**

ValueOptions has improved and further developed its operating policies and procedures since the prior two audits conducted in Fiscal Year (FY) 2006. There is evidence that ValueOptions has improved in all areas, with significant gains made in the following areas:

- Timeliness of Decisions improved from 64% in the FY 2006 2nd Quarter Denial Audit, to 100% reported currently
- Denial Letter Documentation – Denial Reason improved from 92% in the FY 2006 3rd Quarter Denial Audit, to 100% reported currently
- Denial Letter Documentation – Criteria Referenced improved from 53% in the FY 2006 3rd Quarter Denial Audit, to 100% reported currently
- Notification Timeliness – Provider and Consumer improved from 83% in the FY 2006 3rd Quarter Denial Audit, to 100% reported currently
- There were no identified Health Insurance Portability and Accountability Act (HIPAA) violations
- Provider and consumer letters have improved, and address all required components

In context of the Noted Improvements, two additional observation were made: ValueOptions’ score for Case Documentation – Decision Rational slipped from 100% in FY 2006 third quarter to 95% reported currently, and recommended changes to governing policies and procedures that were identified in prior audits have not been addressed by ValueOptions.

**Recommendations**

The recommendations of this review are aimed at facilitating continuous quality improvement of the BH services provided by ValueOptions. With this goal in mind, NMMRA offers the following recommendations for ValueOptions’ and NM HSD’s consideration:

- Revise policy CL203 Medical Necessity Determination, Lack of Information and Notification Timeliness to include the approved UM timeframes for medical necessity determination and notification as an attachment, and provide staff training as needed
- Correct denial letters to reference the full regulation number as “8.305.8.15. (9)”
- Develop a mechanism to ensure that the medical director documentation is consistently recorded in the medical record or information system
- Conduct periodic reviews of utilization review denial files in order to evaluate and identify documentation and timeliness issues
- Recommend ValueOptions develop a quality improvement activity regarding clinical denial determination, which may include a formal Inter Rater Reliability for the medical directors
• Develop clinical staff training programs for new hires and established employees to ensure clinical level-of-care guidelines are being followed at all times

**Reconsideration Review**

ValueOptions reviewed the preliminary findings of the BH UR Denial Draft Audit Report and submitted the following comments, and requested NMMRA reconsider the five disagreement decisions as well as a misclassified denial determination.

**Comments submitted by ValueOptions**

Three of the cases involved denials based on level of care guidelines. Because physicians can have disagreements in clinical judgment, VONM utilizes HSD-approved Level of Care Guidelines to help standardize the approach and minimize anecdotal or empirical approaches to these decisions.

The draft report states on page 10 that NMMRA disagreed with VONM’s denial decision “because ValueOptions did not follow its own prescribed level-of-care guidelines. Yet the case-specific reviews of the first and second-level reviewers make no references to specific Level of Care guidelines or to particular criterion within a level of care (e.g. RTC guidelines contain multiple criterions for admission, continued stay, and for discharge).

Instead, there are general comments such as “this writer disagrees with the denial….appears to meet TFC 2 level of care…..escalating nature of substance abuse and delinquency as well as aggressions strongly support the need for a higher level more restrictive setting…..the review does not agree with the decision…..clinical denial was likely inappropriate.” These comments, while important and possibly valuable clinically, have no meaning in terms of whether or not the Level of Care guidelines were followed appropriately. It is vital that any review by a third party use and refer to our clinical guidelines.

The three cases at issue are listed below (see #1-3) with justifications for the denial decisions made by VONM. **VONM requests that NMMRA reconsider their denial decision disagreement in all 3 cases.**

Two of the cases revolved around ‘sufficient information’. This is, admittedly, a grey area. Generally, speaking, clinical determinations are made based on the available clinical information. Requests for additional information are made and documented. It is often difficult to determine if the information on hand is ‘insufficient’ because it is impossible to know if there is more to be had, or if there just simply is nothing more to say. An example is when the clinical information made available to VONM says nothing about prior outpatient treatment; is this due to provider’s failure to submit this information or because the consumer has never received such outpatient treatment? When VONM does request more information, and none is forthcoming, the Medical Director has the discretion to exercise clinical judgment and make a clinical determination based on the evidence then available.

The two cases at issue are detailed below (see #4 and #5) with an explanation of the denial decisions. **VONM requests that NMMRA reconsider their disagreement in both cases, and reconsider their determination of ‘misclassified denial’ in case #5.**
### Case Detail:

<table>
<thead>
<tr>
<th>Case #</th>
<th>File #</th>
<th>Standard</th>
<th>Concern</th>
</tr>
</thead>
</table>
| 1      | 07-09-1727| EQRO/SE Agreement | **EQRO Reviewer Comment:** "If their recommended (and quite extensive, possibly unrealistic) dc plan was not in place, clinical denial was likely inappropriate."

**VONM Response:** Clinical narrative repeatedly reports “no si or hi” and no report of ACTUAL or POTENTIAL Danger which is the mandatory requirement for ongoing stay in Acute Care. The provider had developed a DC plan of transfer for the State Hospital. This is an inadequate DC plan. Dr. Maviglia in his well-reasoned denial reports that there is no dangerousness and no solid after-care plan. Transfer to LVMC would not address this.

Consumer did not meet Continued Stay Criteria #1; the DC Criteria Part A is met with the exception of the DC planning piece. DAP could be considered since DC plan not adequate.

**Reconsideration Review by NMMRA Contracted Psychiatrist:** Per record review, disagree with denial based on LOC criteria 1) admit criteria 2.201 (6) command hallucinations to harm self & others very significant; VO reviewer opines does not meet criteria 8/22/6 notes indicate hallucinating paranoid, isolating & paranoid 2.201 d/c criteria A or B met 2.201 continued stay criteria 1-5 met. **Disagreement Upheld**

| 2      | 07-09-2155| EQRO/SE Agreement | **EQRO Reviewer Comment:** "Consumer meets RTC criteria."

**VONM Response:** There is no specificity as to which specific RTC criteria are met or not met. In this case the consumer had been in various treatment modalities, but never in hospital. Identified problem is the “resistance presented in the family system”. Also this is a consumer with significant JJS involvement. No dangerousness to self/others. Consumer presently in detention center to leaving home with Ankle monitor. Referred by JPPO to RTC.

This is a case that MST has proven to be very effective in. MST is available in LC area. Consumer did not meet admission criteria 2, 3, 4. Also appears to “substitute for the need for management within the juvenile justice or protective services system” (HSD RTC criteria). RTC does not follow the “least drastic” principle required by MAD regs. MST could be successful with this consumer and family.

**Reconsideration Review by NMMRA Contracted Psychiatrist:** Per record review, disagree with denial based on LOC criteria. RTC denied MST or FFT suggested already failed TFC, was a runaway status despite ankle bracelet. 2.60 fails FFT admit criteria 3 meets exclusion 1; 2.60 fails MST admit criteria 3 meets exclusion 1; meets 3.301 RTC admit criteria 1-6. **Disagreement Upheld**
## BH Utilization Review Denial Audit
### Reconsideration Request Case Detail

<table>
<thead>
<tr>
<th>Case #</th>
<th>File #</th>
<th>Standard</th>
<th>Concern</th>
</tr>
</thead>
</table>
| 3      | 07-09-8305 | EQRO/SE Agreement | **EQRO Reviewer Comment:** “Current problems and escalating nature of substance abuse and delinquency as well as aggression strongly support need for higher level more restrictive setting.”  
**VONM Response:** In this case there is again no history of acute dangerousness, precipitating factor is involvement with JJS, there has been no outpatient treatment and no treatment whatsoever other than an ER visit to Kaseman and Anger Management groups through La Buena Vida, the most recent during 2005. Client does not meet RTC admission criteria 2, 3, 5. Dr. Maviglia appropriately recommended less drastic and restrictive levels of care that could be successful.  
Reconsideration Review by NMMRA Contracted Psychiatrist: Per record review, disagree with the denial based on LOC criteria. VO reviewer opined group home placement is adequate but patient has 3 exclusions 1) 3.30 destructive behavior 2) demonstrated ability to be in society e.g. go to school 3) already failed outpatient anger management.  
**Disagreement Upheld** |
| 4      | 07-09-2591 | EQRO/SE Agreement | **EQRO 1st Reviewer Comment:** “Per record review, the telephonic review information in chart has insufficient information to determine TFC2 level of care.”  
**EQRO 2nd Reviewer Comment:** “Consumer also has borderline intellectual functioning even with scant information provided appears to meet TFC2 LOC.”  
**VONM Response:** The two reviewer comments appear to conflict – 1st level implies it was appropriate to deny; 2nd level implies it should have been approved.  
Dr. Maviglia exercised his clinical judgment and determined that there was sufficient information to make a clinical determination. The denial was based on the fact that the prior history did not include a lower level of care, which is one of the criterions for TFC2. Per TFC2 LOC guidelines, consumer does not meet #4. Foster care, with appropriate services to help with the condition of this child could be successful in treating the issues that exist. There is no acuity indicated that would lead to a more drastic approach.  
Reconsideration Review by NMMRA Contracted Psychiatrist: Per record review, disagree with denial based on LOC criteria. Provider requested TFC2, VO denied RTC rationale for TFC2 A4 no prior TX but no clinical information about prior treatment. Both parents incarcerated and in consumer in CYFD custody. 1) Wrong criteria cited, 2) Insufficient clinical history obtained.  
**Disagreement Upheld** |
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| 5      | 07-09-0823 | Misclassified Denial | **EQRO Reviewer Comment:** "Dr. Maviglia states that clinical information provided made it difficult to assess need for placement."

**VONM Response:** Dr. Maviglia determined that the information presented was ‘not well delineated and explained.’ This is not the same as ‘insufficient.’ Dr. Maviglia exercised his professional judgment that the information was sufficient enough to accept and to base a clinical determination on. The reasons cited in his documentation (‘not well delineated and explained’) were offered as feedback to the provider.

NMMRA also determined that this case was misclassified and should have been an administrative denial. **VONM requests that NMMRA reconsider their determination of ‘misclassified denial’.**

**EQRO Reviewer Comment:** “…additional information should have been requested…” Notes indicated request for RTC was from Memorial but reviewer noted that she requested additional information from UNM, who did not respond.

Reconsideration Review with HSD regarding misclassified denial: Based on VONM’s policy CL203 Medical Necessity Determination, Lack of Information and Notification Timeliness states “If additional information is not received, an administrative denial can be issued,” This criterion was not applied to this denial case. The on-site interview with VONM staff presented this case, CL203 policy was not applied and the VONM staff agreed with NMMRA determination that this case was misclassified. **Misclassified Denial Upheld**

**VONM Response:** The documentation that the provider was at UNM, and not at Memorial, is admittedly, a mistake. However, elsewhere in the record, Mary Shannon Palmer is clearly identified as staff at Memorial. In addition, it is documented that provider was contacted twice with a request for more information. It is also documented that there was no response to the request. As stated above, Dr. Maviglia exercised his professional judgment that the information was sufficient enough to accept and to base a clinical determination on.

Reconsideration Review by NMMRA Contracted Psychiatrist
Per Record Review, disagree with denial based on LOC criteria. 1) As above insufficient evidence should have been pursued from correct source. 2) 3.301 A1-6 met - was in RTC removed AMA, homelessness; 3.301 exclusion criteria 2 is problematic. **Disagreement Upheld**
Reconsideration Decision
The reconsideration review was conducted by NMMRA’s contracted psychiatrist and findings were reviewed with NM HSD. Additional evidence submitted by ValueOptions as of February 14, 2007 was included in the reconsideration review process. Documentation that fell outside the audit timeframe and documentation submitted after the end on business on the last day of the on-site visit was not allowed unless NM HSD determined the evidence to be valid.

Reconsideration Request: Three of the cases involved denials based on level of care guidelines
NMMRA’s review of ValueOptions’ reconsideration request documentation and re-examination of audit documentation demonstrated that ValueOptions did not follow MAD regulations and/or its HSD approved level-of-care guidelines to ensure appropriate denial of BH services. The EQRO/SE Agreement Rate for the case score and the aggregate score were not adjusted.

Reconsideration Request: Two of the cases revolved around ‘sufficient information’
Review of ValueOptions’ reconsideration request documentation and re-examination of audit documentation demonstrated that ValueOptions did not follow its approved HSD level-of-care guidelines and policies and procedures to ensure appropriate denial of BH services related to insufficient information. The EQRO/SE Agreement Rate for the case score and the aggregate score were not adjusted.

Conclusion
Based on the NMMRA’s compliance review of MAD regulations, evidence acquired during the scope of this audit, interpretive guidelines and the scoring methodology approved by NM HSD, NMMRA finds ValueOptions’ earned the following designation for the MAD standards and contractual requirements examined:

- Case Review – Full Compliance
- Agreement Rate on Denial Decisions for Administrative Review – Superior
- Agreement Rate on Denial Decisions for Clinical Review – Opportunity For Improvement

Specific findings are included in the Appendices. The scoring methodology approved by NM HSD requires that any single MAD regulation receiving a minimally compliant or non-compliant designation be placed on corrective action. Based on this requirement, NMMRA informs NM HSD of the opportunity for improvement based on the Agreement Rate on Denial Decisions for Clinical Review.

Note: NMMRA’s preliminary findings for this audit were presented to NM HSD on January 16, 2007. Shortly thereafter the NM Behavioral Health Collaborative Agency meeting VONM presented its input on Medicaid program changes on January 18, 2007. Based on these two reports, HSD initiated a Clinical Focus Denial Audit dated January 23, 2007, LOD 07-14. This audit is currently in progress, findings will be reported on April 2, 2007 by NMMRA.