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Executive Summary

The New Mexico (NM) Human Services Department (HSD) has contracted with New Mexico Medical Review Association (NMMRA) as the NM External Quality Review Organization (EQRO) to conduct monitoring, auditing, surveying activities regarding the performance of the contracted organization and to provide HSD with valid and reliable information and data. HSD issued Letter of Direction (LOD) No. 08-03 on July 11, 2007 to NMMRA to conduct a focused continuum of care audit of Behavioral Health (BH) services. This included a review of clinical denials, approvals, care coordination, grievances, appeals, expedited appeals, and fair hearings of the single statewide entity (SE), ValueOptions of New Mexico (VONM) for the month of June 1 through 30, 2007. The scope of work addressed all appropriate Medical Assistance Division (MAD) regulations, and was performed in accordance with NMMRA’s EQRO contract, Article 1.3.16.

The objectives of this report are to measure and score the performance of VONM against the state’s HSD Managed Care Regulations, in particular 8.305.8.13, Utilization Management, 8.305.9, Coordination of Services and 8.305.12, MCO Grievance System. This external quality review study provides audit results and the basis to make recommendations for improvement in the quality of BH services provided to consumers. This report describes how NMMRA completed the audit and scored VONM’s performance. Data were analyzed both in aggregate and in detail to determine compliance with each section of review. This report also explains the methodologies used to audit the completeness of documentation and measure compliance with the required standards as well as identifying opportunities for improvement.

The expanded scope of this audit, as requested by HSD, was comprised of a comprehensive review of a managed care consumer’s entire service request continuum. This audit reviewed all related authorizations, clinically related denials, subsequent care coordination referrals and follow up, as well as appeals, grievances, expedited appeals or fair hearings associated with the denials.

The BH Continuum of Care Audit was based on 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 VONM earned the following designation for the respective MAD standards and contractual requirements for the following scored components:

- Case Review – Full compliance (96%)
- Coordination of Services – Minimal compliance (66%)

The combined overall score for the BH Continuum of Care Audit is 89% to earn a rating of Moderate compliance.

Corrective action is recommended for areas scoring minimal compliance. A comparison of the previous clinical denial audits and recommendations are found within the detailed report.
Background

In July 2005, HSD, along with multiple state agencies, implemented the first phase of its BH System Transformation. This restructuring created one statewide entity (SE) for behavioral health services to serve as the single entity providing coordination, planning, administration and monitoring of all aspects of the NM BH managed care system. The contract, including a prepaid capitation model, was awarded to VONM. VONM collaborated with the Behavioral Health Purchasing Collaborative and in turn contracted with community-based and independent providers to administer services statewide. As a requirement of its SE contract, VONM is required to comply with the NM Medicaid managed care regulations, which stipulate the standards for access, structure and operations, quality measurement and improvement.

This audit represents an expanded utilization review (UR) from previous denial audits aimed at evaluating the continuum of care for BH Managed Care Medicaid consumers. Included are comparative scores from previous UR denial audits.

Audit Approach and Methodology

The audit approach and methodology were designed to align the audit process with VONM’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 audit approach (as well as the scoring methodology), was designed according to the New Mexico Administrative Code (NMAC) 8.305.8.13 Utilization Management (UM), 8.305.9. Coordination of Services, and 8.305.12, MCO Grievance System regulations.

NMMRA was directed by NM HSD to specifically include the following points in the audit scope of work to determine if VONM had evidence of:

- Development of a mechanism to ensure that the Medical Director’s documentation is consistently recorded in the medical record or information system.
- Inclusion of relevant clinical information in medical records.
- Revision of Policy CL203.
- Development of a quality improvement activity regarding clinical denial determination.
- Identification of expedited appeals for urgent requests.
- Referrals to care coordination when initial service requests are denied.

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 consisted of recorded denials of BH services for Medicaid managed care consumers during the audit period as reported in Report HSD 2 detailed denial report by VONM to NM HSD in each of the following settings: residential treatment center (RTC), treatment foster care (TFC) and acute inpatient care. The universe was defined by NM HSD to identify any patterns in clinically related denials. The sample is targeted and non-random.

Based on the universe provided and in consideration of the tasks listed above, it was determined that out of the original 75 cases reported by VONM to HSD only 58 cases met the requirement for the audit sample. The inaccuracies in the reporting are due to erroneous inclusion of consumers in report HSD 2 as evidence by the following:

- 6 Fee-for-Service consumers, were included in the Managed Care HSD 2 Report
- 3 consumers were not eligible to receive Medicaid benefits at the time of the service request
- 8 consumers' denial determinations were completed in the month of May

The audit sample was designed to be representative of:

- The population eligible for Medicaid BH services by demographic characteristics, geographic distribution, and enrollment.
- The eligible providers serving the NM Medicaid population.
- The setting types of services: RTC, TFC, and acute inpatient psychiatric hospital.

**Audit Tool and Guide**

The Behavioral Health Utilization Review Denial Audit Guide and Tool were developed using NMAC and NM MAD regulations 8.305.8.13, 8.305.9, and 8.305.12. 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.

**Audit Overview**

Approximately one month prior to the scheduled audit engagement, NMMRA conducted an audit overview meeting with representatives from VONM and HSD. The meeting provided an opportunity to review the audit scope, audit timeline, regulations, and the data source documentation lists. In order to perform the medical record and file reviews for the audit, NMMRA provided, in writing at the close of the meeting, the information for the universe selection and data source documentation lists. VONM was given two weeks to submit the required documentation. Prior to the on-site visit, NMMRA examiners reviewed the requested documents to expedite the on-site process, encourage communication between NMMRA and VONM, and expedite the clarification and on-site interview process.

**On-site Meeting**

NMMRA conducted an opening conference with key personnel from VONM on August 1, 2007. 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 EQRO medical director in relation to potential quality of care cases, suspected fraud and abuse cases and second-level review. VONM received a detailed site-visit agenda at the meeting. Following NMAC standards and NMMRA’s Behavioral Health Utilization Review Denial Audit Guide and Tool, NMMRA
examiners collected detailed information assessing VONM’s compliance with the defined standards.

The on-site visit lasted two days and was conducted by NMMRA examiners. NMMRA examiners reviewed all cases in the sample and reviewed VONM’s utilization management (UM) and Care Coordination policies and procedures governing denials. This included criteria for the use of clinical information, documented criteria, timeliness standards, and referrals to care coordination.

NMMRA reviewed 58 UM clinical denial cases to assess compliance with applicable MAD standards, citation of the MAD medical necessity definition and correct application of approved HSD level-of-care criteria. The cases selected represented RTC, TFC and acute inpatient services. Case review files that did not score 100% were discussed on-site with VONM’s UM staff to ensure all documentation was made available to NMMRA examiners and NMMRA examiners interviewed VONM’s staff to obtain clarification on incomplete cases.

At the conclusion of the on-site visit, NMMRA presented its preliminary findings, provided feedback, and answered questions. At NMMRA’s request, the VONM’s attendees completed an event evaluation. The evaluation was based on a five-point scale, with five being the highest and one the lowest approval rating. An aggregate average of 4.3 was scored, indicating satisfaction with the audit engagement. Attendees were “satisfied” with the audit overview process and preliminary findings documentation provided by NMMRA.

**Scoring Methodology**

**Overall Indicators**

In assessing the SE’s performance, the EQRO addressed the following indicators in addition to scoring case-level performance.

- Assessment of consistent application of the SE’s clinical criteria in denial decisions based on State-approved definitions.
- Patterns of utilization denials – Are there any 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**

A numerical system was used to arrive at a score for each regulation, each category, and an overall score for the SE’s performance.

Table 1 presents each case in the sample selected for review and evaluated using the Behavioral Health Continuum of Care Audit tool. A numerical score of one or zero was assigned to each regulation element.
Table 1. Case Review Scoring

<table>
<thead>
<tr>
<th>Regulation Element</th>
<th>Types of Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-certification (Routine)</td>
</tr>
<tr>
<td>Request Type Timeliness</td>
<td>1</td>
</tr>
<tr>
<td>Case Documentation</td>
<td></td>
</tr>
<tr>
<td>Physician Review</td>
<td>1</td>
</tr>
<tr>
<td>Denial Rational</td>
<td>1</td>
</tr>
<tr>
<td>Criteria</td>
<td>1</td>
</tr>
<tr>
<td>Relevant Clinical Information</td>
<td>1</td>
</tr>
<tr>
<td>Denial Letter Notification</td>
<td></td>
</tr>
<tr>
<td>Denial Reason</td>
<td>1</td>
</tr>
<tr>
<td>Criteria Referenced</td>
<td>1</td>
</tr>
<tr>
<td>Copy of Criteria Available</td>
<td>1</td>
</tr>
<tr>
<td>Reviewer Availability</td>
<td>1</td>
</tr>
<tr>
<td>Appeal Rights</td>
<td>1</td>
</tr>
<tr>
<td>Notification Timeliness</td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>1</td>
</tr>
<tr>
<td>Consumer</td>
<td>1</td>
</tr>
<tr>
<td>Expedited Appeal (Urgent)</td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>0</td>
</tr>
<tr>
<td>Consumer</td>
<td>0</td>
</tr>
<tr>
<td>Expedited Appeal (Concurrent)</td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>0</td>
</tr>
<tr>
<td>Consumer</td>
<td>0</td>
</tr>
<tr>
<td>Coordination of Services</td>
<td></td>
</tr>
<tr>
<td>Collateral Clinical Information</td>
<td>1</td>
</tr>
<tr>
<td>Contact Consumer</td>
<td>1</td>
</tr>
<tr>
<td>Primary Point of Contact</td>
<td>1</td>
</tr>
<tr>
<td>Plan of Care Completion</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

EQRO also examined the scores within each measurement criterion above to determine if there are patterns of performance deficiency where recommendations for quality improvement activity may be appropriate.

**Compliance Levels**

The individual case scores were summed and aggregated, and then a percent overall score was determined, interpreted as follows:

<table>
<thead>
<tr>
<th>Earned Designation</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full compliance</td>
<td>90 – 100%</td>
<td>SE has met or exceeded regulation requirements</td>
</tr>
<tr>
<td>Moderate compliance</td>
<td>80 – 89%</td>
<td>SE has met most requirements of the regulation</td>
</tr>
<tr>
<td>Minimal compliance</td>
<td>50 – 79%</td>
<td>SE has met some requirements of the regulation, but has significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>&lt; 50%</td>
<td>SE has not met requirements of the regulation and requires mandatory corrective action</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
Some elements may be evaluated as yes, no, or N/A; yes and N/A are treated equivalently when determining the case review score.

**Calculation of Final Overall Score**

The available points per regulation are multiplied by the appropriate weight according to the assigned designation to calculate the achieved points for that regulation. The achieved points for all the regulation standards in the regulation elements are then summed to calculate the total assigned points for all regulations. Summing the total points assigned per regulation element then derives the final overall score. A percentage is calculated for each regulation to determine the compliance designation.

**Other Case Review Measures**

- **EQRO/SE Decision Agreement Rate**
  - Recommendations only – no corrective action

- **Authorizations**
  - Recommendations only – no corrective action

- **Potential Quality of Care**
  - Recommendations only – no corrective action

- **Suspected Fraud & Abuse**
  - Recommendations only – no corrective action

- **MCO Grievance System**
  - Recommendations only – no corrective action

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

Examiner IRR was maintained through the assignment of audit responsibility to the primary NMMRA examiner, 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 examiner 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 examiners, and internal logic and reasonableness. The primary NMMRA examiner also conducted peer review of each section to ensure consistency in assigning designation, scoring, and language.

An IRR assessment was conducted on 12 cases or 20% of the sample. A sample size of 20% is considered reasonable to sustain 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 examiners, and findings were reviewed with NMMRA EQRO staff for training purposes.
Findings

Table 2 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 calculating a percent overall score.
- Assigning a level of compliance designation based upon the percent overall using the following approved scale:

  - Full compliance: 90 – 100%
  - Moderate compliance: 80 – 89%
  - Minimal compliance: 50 – 79%
  - Non-compliance: below 50%

NMMRA conducted three BH UR denial audits over the last year. VONM has shown overall improvement in the following areas: timeliness of denial decisions, required components of the denial letter, and notification timeliness. Improvement has been noted in the case file documentation by VONM care coordinators.

NMMRA noted in the last three denial audits that the medical director’s denial decision documentation based on the HSD approved level-of-care guidelines was inconsistently documented. However, for this audit, the VONM medical director improved the performance of documenting the level-of-care guidelines in comparison with the prior denial audits conducted in FY 2007. NMMRA examiners noted the VONM contracted peer advisor not referencing the denial decision documentation affected the score for this category.

The final overall score for case review and the non-scored EQRO/SE agreement with denial decision is displayed in Table 2.

Table 2. Final Overall Score for Case Review and Non-scored EQRO/SE agreement with denial decision

<table>
<thead>
<tr>
<th>Review Period</th>
<th>FY 07 June</th>
<th>FY 07 Dec/Jan</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>
<td>Score</td>
<td>Score</td>
</tr>
<tr>
<td>Case Review Points</td>
<td>718 out of 746</td>
<td>96%</td>
<td>96%</td>
<td>99%</td>
<td>84%</td>
</tr>
<tr>
<td>Non-Scored Area for FY 07 June</td>
<td>55 out of 58</td>
<td>N/A</td>
<td>83%</td>
<td>79%</td>
<td>83%</td>
</tr>
</tbody>
</table>
Case Review

VONM scored 718 points out of a possible 745 points, to score at 96% and earned a rating of **Full compliance** in Case Review. Although the score reflects VONM has made improvement in its written processes, the organization needs to demonstrate improvement with the level-of-care criteria documentation, notification timeliness to providers and consumers, and consistently following the process for reconsiderations.

During the audit, NMMRA reviewed four case files for which the clinical denial decision had been overturned during reconsideration. The overturned denial determination was based on physician-to-physician communication providing additional clinical information for each individual case. VONM’s policy and procedure CL303 Medical Necessity Determination states reconsideration after the 3-business day timeframe will not be considered and a clinical appeal needs to be filed. The reconsideration process was not consistently followed based on VONM’s policy and procedure of a three-day turn around time from the denial determination.

**EQRO/SE Agreement**

Per HSD direction, NMMRA examiners reviewed the medical director’s denial decision based on level-of-care guidelines to ensure consistency of review decisions. A review of a sample of 58 clinical records was conducted, and NMMRA agreed with 55 of 58 clinical records.

Following NMMRA’s first-level review, four cases were sent by NMMRA’s examiners to second-level review because NMMRA examiners disagreed with VONM’s medical director denial decisions. The second-level reviewer(s) agreed with NMMRA’s disagreement opinion on three of the four cases. This specific element was reviewed for recommendations only and not corrective action based on direction from HSD.

The EQRO Disagreement rate with SE Denial Decision is included in Appendix 3.
Case Review by Section

Table 3 below displays summary scores by section to include the percentage score and compliance designation for each element of case review.

Table 3. Summary Scores by Section for Case Review

<table>
<thead>
<tr>
<th>Regulation Standard</th>
<th>Percentage Score</th>
<th>Compliance Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8.305.8.13. Utilization Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Request Type Timeliness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.305.8.13(E) Timeliness of Decisions</td>
<td>98%</td>
<td>Full compliance</td>
</tr>
<tr>
<td><strong>Case Documentation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.305.8.13. (D2) Physician Review</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td>8.305.8.13(D4) Decision Rationale</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td>8.305.8.13. (B3) Criteria</td>
<td>73%</td>
<td>Minimal compliance</td>
</tr>
<tr>
<td>8.305.8.13.F3) Relevant Clinical Information</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td><strong>Denial Letter Documentation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.305.8.13. (G3) Denial Reason</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td>8.305.8.13. (G) Criteria Referenced</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td>8.305.8.13. (B5) Copy of Criteria Available</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td>8.305.8.13. (G2) Reviewer Availability</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td>8.305.8.13. (A/B) Appeal Rights</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td><strong>Notification Timeliness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.305.8.13(E) Notification Timeliness/Provider</td>
<td>88%</td>
<td>Moderate compliance</td>
</tr>
<tr>
<td>8.305.8.13(E) Notification Timeliness/Consumer</td>
<td>88%</td>
<td>Moderate compliance</td>
</tr>
<tr>
<td><strong>Expedited Appeal (Urgent Requests)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expedited Appeals Occurred – Provider</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td>Expedited Appeals Occurred – Consumer</td>
<td>100%</td>
<td>Full compliance</td>
</tr>
<tr>
<td><strong>Expedited Appeal (Concurrent Requests)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expedited Appeals Explained – Provider</td>
<td>100%</td>
<td>Full Compliance</td>
</tr>
<tr>
<td>Expedited Appeals Explained – Provider</td>
<td>100%</td>
<td>Full Compliance</td>
</tr>
</tbody>
</table>

VONM scored 73% for documentation of level-of-care criteria for a denial determination of requested services and earned a rating of Minimal compliance. The VONM medical director improved the performance of documenting the level-of-care guidelines in comparison with the prior denial audits conducted in FY 2007. NMMRA examiners noted, however, that the VONM contracted peer advisor not referencing the denial decision documentation affected the score for this category.

VONM scored 88% for notification timeliness to providers and consumers to earn a rating of Moderate compliance.
VONM has not addressed all recommendations provided in previous audits. Specifically to:

- Develop and implement a medical director IRR process to ensure appropriate level-of-care referrals.
- Document the specific level-of-care guidelines used for the basis of the denial and ensure the medical director cites specific criteria when services are denied. Internal VONM medical directors have improved in documenting criteria but records reviewed by contracted physicians continue to lack documentation of criteria.

Utilization Management staff and the medical director made recommendations for services during the course of the clinical denial; however, evidence of authorizations or claims for services was not consistently noted in consumer files.

**Coordination of Services**

In previous BH UR audits, NMMRA noted the need for changes in the care coordination referral process. In the last focused denial audit, the recommendation to develop a policy and procedure for care coordination referrals to care coordination when initial service requests are denied was in the revision process. Although the VONM medical director referred the case for follow-up by a Specialized Care Coordinator (SCC), this was not consistently evidenced in the case files. For example, case files demonstrated contact with consumers did not occur in a timely manner or there was no contact with the consumer.

NMMRA audited 58 cases for Coordination of Services, based on VONM’s policy and procedure CL 171 Specialized Care Coordination Program. The policy and procedure included the following components:

- Specialized Care Coordinator (SCC) reviewing collateral clinical information within five days of receipt of referral.
- Contact with the consumer unless this is contraindicated.
- Documentation and advising the consumer the SCC is the primary point of contact;
- Completion of a plan of care within 10 days of direct contact with the consumer or provider.

All of the above components were scored elements for each individual case. VONM scored 152 points out of a possible 232 points to score a 66% and earn a rating of **Minimal compliance**.

The Summary Scores by Section and Detail Scores Report are included in Appendix 1 and Appendix 2 of this report.

Table 3 presents the final scores for Coordination of Services.
Table 3. Coordination of Services

<table>
<thead>
<tr>
<th>Scored Elements</th>
<th>Total</th>
<th>Score</th>
<th>Earned Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collateral Clinical Information</td>
<td>41 out of 58</td>
<td>71%</td>
<td>Minimal compliance</td>
</tr>
<tr>
<td>Contact Consumer</td>
<td>52 out of 58</td>
<td>86%</td>
<td>Moderate compliance</td>
</tr>
<tr>
<td>Primary Point of Contact</td>
<td>30 out of 58</td>
<td>52%</td>
<td>Minimal compliance</td>
</tr>
<tr>
<td>Complete Plan of Care</td>
<td>29 out of 58</td>
<td>58%</td>
<td>Minimal compliance</td>
</tr>
<tr>
<td>Overall Score – Coordination of Services</td>
<td>152 out of 232</td>
<td>66%</td>
<td>Minimal compliance</td>
</tr>
</tbody>
</table>

Authorizations

NMMRA examiners reviewed 58 cases to determine if VONM authorized the recommended services (which require authorization) after a clinical denial of services. The results are as follows:

- 35 out of 58 case files had an authorization for recommended services
- 23 out of 58 case files did not have an authorization for recommended services

Per HSD direction, this section is not a scored measure. NMMRA examiners reviewed this area for recommendations and not corrective action. VONM was unable to consistently provide evidence that consumers receive services after a clinical denial of services.

The Authorizations are included in Appendix 4.

Potential Quality of Care

No potential quality of care cases was identified.

Suspected Fraud and Abuse

No suspected fraud and abuse cases were identified.

Member Grievance System

NMMRA audited 58 cases to determine if VONM complied with its process for grievances, appeals, expedited appeals, and fair hearings. NMMRA reviewed case files to determine if consumers received benefits during the appeals, expedited appeals or fair hearing process. Per HSD direction, this section is not a scored measure. NMMRA examiners reviewed this area for recommendations only and not corrective action.

VONM reviewed eleven appeal cases, three expedited appeal cases, and one fair hearing case. Of the 11 appeal cases five of the clinical denial decisions were upheld, with five overturned. One case is currently under the fair hearing process and had not been resolved during the time of the audit. There were three expedited appeal cases and the clinical denial decisions were upheld.
The Member Grievance System is included in Appendix 5.

**Recommendations**

Subsequent to the previous BH UR denial audits, NMMRA provided VONM recommendations for improvement in the final audit report. This was done to help facilitate continuous quality improvement of BH care provided by VONM. Full compliance for each standard is both the goal and the expectation, as the standards are well delineated by NM HSD.

Upon review of the BH UR denial audit final report, NM HSD requested that NMMRA include in the final report specific actions/activities that NM HSD is requiring of VONM. These include:

- Revise policy CL 203 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 (this has not been implemented since the first quarter FY07 denial audit).
- Develop and implement a process to ensure that recommended services are authorized timely from the date of the denial determination.
- Develop a process for timely care coordination referrals after a clinical denial has occurred.
- Develop a process for SCCs to offer consumers/families alternative services in lieu of or in addition to care coordination services (i.e., consumer discharged from RTC, consumer receives the necessary recommended services and care coordination occurs to follow up with consumer for continuity of care).
- Develop a process on how follow-up care is monitored subsequent to a referral for care coordination from the medical director.
- Develop a process for VONM staff to document the following:
  - Review of clinical collateral information
  - Contact with consumer or provider
  - Advises the consumer SCC point of contact
- Develop a process for VONM staff to complete the Comprehensive Care Coordination Plan within 10-business day of direct consumer or provider contact.
- Conduct an internal audit of Specialized Care Coordination files to ensure compliance with the VONM Specialized Care Coordination Program policy.
- Conduct an internal audit on the frequency and type of denial decision cases that are overturned on second-level review.
- Develop and implement training for peer advisors to document the exact level-of-care guidelines used for the basis of the denial and ensure the medical director cites specific criteria when services are denied. For example “does not meet criteria 3.30.1.1 RTC admission criteria #1 and #3.”
- Develop and implement a process to ensure accuracy of data compiled for the HSD 2 and all other reports before submitting to HSD.
- Develop and implement process to ensure the denial notifications are timely to the provider and consumer.
- Develop and implement a process for reconsiderations to occur within the three-day turn around time from the date of denial to be consistent with VONM’s policy and procedure.
- Develop and implement a process to track discharge follow-up from inpatient treatment facilities to ensure timely services.
Reconsideration Review
VONM reviewed the preliminary findings of the BH Continuum of Care Audit Draft Report and provided an opportunity to respond with specific questions, comments, and requests. Below are the reconsideration review responses from VONM indicated in italics with NMMRA’s corresponding bolded response.

1. **Page 1 – Executive Summary, 4th paragraph and Page 12 - Conclusion:**
   - Two of the four bulleted items are non-scored items and should be deleted from this list to be consistent with “Other Case Review Measures” on page 6. Additionally, per 6/20/07 meeting and again at the audit overview, HSD agreed to track “SE/EQRO Decision Agreement Rate” for recommendations only. Per conference call 10/18/07, given the confusion around regulatory requirements for continuation of benefits, HSD agreed to track “Grievance Tracking” for recommendations only.
   - **NMMRA agrees and has made the appropriate changes to the report.**
   - The overall score should be revised to 89% per revised Detail Case Scores spreadsheet.
   - **NMMRA agrees and has made the appropriate changes to the report.**

2. **Page 5 – Table 1: Member Grievance System should be deleted from the table and total points revised to reflect that “Continuation of Benefits” is not a scored element. Additionally, throughout the report, ‘Member Grievance System’ seems to be used interchangeably with ‘Grievance Tracking’ which is confusing.**
   - **NMMRA agrees and has made the appropriate changes.**

3. **Page 7 – Findings, 3rd paragraph: The sentence that begins “An area of significant concern” is unclear. It would be helpful if this sentence were reworded.**
   - **NMMRA agrees and has made the appropriate changes.**

4. **Page 7 – Table 2: “Case Review Points” should be revised to reflect subsequent finding that the three expedited appeals were handled in a timely manner, per telephone conversation with NMMRA staff on 10/19/07. Additionally, “SE/EQRO Decision Agreement Rate” should be deleted from the table since this element is for tracking and recommendations only (see above).**
   - **NMMRA agrees and has made the appropriate changes.**

5. **Page 7 – Case Review, 1st paragraph: The report states that “VONM continues to struggle with notification timeliness”. VONM acknowledged at the pre-audit overview meeting that UM staffing transitions in early June led to delayed written notifications in early June but that these issues have since been resolved. This was noted, as well, during the onsite audit. Therefore, it is not accurate to say that VONM “continues to struggle”. In addition, it should be noted that although there were delays in some written confirmations of denial decisions, providers were verbally notified of denial decisions in a timely manner, as documented in the case files.**
NMMRA agrees with VONM that there were staffing changes that impacted timeliness of notifications. Based on VONMs implemented staffing changes, this issue is now resolved.

6. Page 7 – Case Review, 1st paragraph: The report states that “VONM continues to struggle with consistently following the process for expedited appeals.” This finding should be deleted in accordance with subsequent finding that the three expedited appeals were handled in a timely manner, per telephone conversation with NMMRA staff on 10/19/07.

NMMRA agrees and has made the appropriate changes.

7. Page 8 – SE/EQRO Agreement Rate, 1st paragraph: As noted above, this is a non-scored element and references to a percentage score or compliance rating should be deleted.

NMMRA agrees and has made the appropriate changes.

8. Page 8 – Table 3: Scores should be revised to reflect subsequent 100% score for Expedited Appeals.

NMMRA agrees and has made the appropriate changes.

9. Page 9 – 3rd paragraph regarding expedited appeals: This paragraph should be deleted given subsequent finding that the three expedited appeals were handled in a timely manner (see above).

NMMRA agrees and has made the appropriate changes.

10. Page 9 – 4th paragraph:

   - The report states that “VONM has not addressed all recommendations provided in previous audits”, however, in bullet two of that paragraph, it states that “VONM medical directors have improved in documenting criteria” Therefore, VONM has addressed this recommendation; VONM continues to need improvement, but the item has been addressed.

   NMMRA has made the appropriate changes however, this bullet relates to training of the contract peer advisors.

   - In reference to bullet one, a medical director IRR process is being addressed as part of a new Directed Corrective Action Plan issued to VONM by HSD in response to the Focused Denial audit in February 2007. A new IRR tool will be administered to all UM staff including all MDs. In addition, an IRR toll will be administered to all UM staff on a monthly basis until further directed by HSD.

   NMMRA notes VONM is implementing a new process.

11. Page 9 – 5th paragraph and Page 10 – Authorizations: VONM strongly objects to the conclusion drawn from the data point presented in this section (the percentage of case files which either did or did not have an authorization for recommended services), specifically “evidence of authorizations or claims for services was not consistently noted in consumer files” (p.9) and “VONM was unable to provide evidence consistently that consumers receive services after a clinical denial of services.” (p.10)
VONM provided additional documentation as part of the reconsideration review indicating current authorizations or claims and many cases indicating consumer-receiving services after a denial. This information was not provided during the audit time frame. NMMRA reviewed the additional documentation and made the appropriate changes.

Files prepared for this audit included any available authorizations, as requested; claims were not requested, but some claims were provided if available at the time of the audit. VONM objects to the use of this data point as the sole measure of whether or not a consumer received services after a clinical denial. VONM does recommend alternate levels of care (LOC) upon a denial, but that does not guarantee that the recommended LOC will be the LOC received or even that the consumer will choose to follow through with receiving services (e.g. if the consumer or guardian refuse treatment). In addition, authorizations are only one way to explore alternative service received since many of the BH services do not require prior authorization. The only way to truly determine whether or not services are received is through claims data. However, the audit was held at the end of August which did not allow for a complete claims record given the claims submission and processing lag time.

The report is misleading in that it implies that because there was no evidence of an auth, there was no care. This is not the case. We have used NMMRA’s “Authorizations” spreadsheet documenting their findings to add VONM’s comments for each case determined to be missing an authorization. (Note the two additional columns marked in blue.) In all cases, progress notes were included in the audit files and indicate care coordinator involvement in follow-up care. In some cases, the consumer refused to access services. It is not clear why these progress notes documenting SCC involvement were not considered as evidence of continuity of care. If further clarification is needed, we would welcome the opportunity to discuss our comments.

NMMRA reviewed the 14 case files and determined that 5 cases met the criteria for authorization for recommended services. Of the 5 cases, 3 had been scored and received an N/A which results in a point received. Other cases reviewed for care coordinator involvement was not during the audit time frame. The SCC documentation was reviewed by the NMMRA examiners, VONM was given credit if the documentation occurred during the audit time frame. Case documentation of care coordination documented in the month of August was not given credit due to the fact this was not during the audit time frame.

According to the draft report, 42% of the case files did not have an authorization for recommended services; yet the Authorization spreadsheet only cites 14 of 59 (23.7%) case files as ‘no evidence in chart of authorized services. Additionally, 2 of those 14 cases are cases where the recommended alternate LOC is for outpatient services which are open-access – this is even noted in the ‘Case Documentation’ column completed by NMMRA. Although it is not clear what value there is in measuring the presence of authorizations, if such tracking is to be included in the audit report, we request that the percentage be corrected.
NMMRA reviewed the 14 case files and determine that 5 cases met the criteria for authorization for recommended services. Of those 5 cases, 3 had been initially scored an N/A, which results in a point received. Other cases reviewed for care coordinator involvement were reviewed and the documentation was not during the audit time frame. The score was adjusted accordingly; the total number of cases without an authorization is 23 out of 58 (40%).

- This section, as written, implies that VONM is required to automatically enter an authorization for the alternative recommended LOC. This is not the case – there is no such MAD regulation and VONM is not aware of any other directive that would require us to do so. It is VONM policy to enter an authorization only when a provider is ready to request services and can justify medical necessity.

Per LOD 08-03, HSD directed NMMRA to review authorizations as part of the Continuum of Care Audit.

- It is not clear why such emphasis is placed on authorizations. VONM requests that this section be deleted or revised to reflect accurate percentages, to clarify that authorizations do not, in and of themselves, serve as an adequate measure as to whether a consumer got services after a denial decision, and to reflect that VONM is not required to automatically enter an authorization for the alternative recommended LOC after a denial.

Per LOD 08-03, HSD directed NMMRA to review authorizations as part of the Continuum of Care Audit.

12. Page 9 – Coordination of Care, 3rd paragraph and Page 10 – Table 3: Points may need to be revised given subsequent elimination of a case file with a denial date prior to the audit timeframe.

NMMRA agrees and has made the appropriate changes.

13. Page 10 – Table 3: VONM respectfully reiterates our disagreement with the points deducted for files that clearly documented ongoing contact with a consumer/guardian, but did not specifically contain the words “point of contact”. Docking for this is a “letter of the law” perspective and seems to reject the “spirit of the law”, which is contact with consumers/guardians and attempting to ensure continuity of care, as documented in the progress notes of those files.

VONM was given credit for SCC unable to contact letter but NMMRA was unable to give credit if SCC did not document point of contact as stated in HSD regulations.

14. Page 10 – Member Grievance System: VONM requested that NMMRA provide a written interpretation defining the requirements for continuation of benefits prior to VONM finalizing this request for reconsideration. As of this submission, such document was not made available. However, the section should be revised to reflect that this section is a non-scored element. Additionally:

- This part of the audit was based on HSD regulations in NMAC 8.305.12.12.B which lists specific requirements that must be met in order for the SE to continue benefits while an appeal or fair hearing is pending. One of those requirements is that the member must specifically request such a continuation. During the conference call, all parties agreed that none of the cases under review involved a member request for continuation of benefits. Therefore, this regulation is non-applicable for all case files under review for this audit.
In past audits, VONM was deemed compliant with this requirement as evidenced by denial and appeal letters which explain consumer rights to request continuation of benefits, the specific situations to which such rights apply, timeframes for doing so, and the potential financial liability the consumer might incur. VONM is not aware of any new regulations related to continuation of benefits and our denial and appeal letters have not been revised since those previous audits.

Per LOD 08-03, HSD directed NMMRA to review evidence of continuation of benefits as part of the Continuum of Care audit.

Per conference call of 10/19/07, discussion of ‘reconsiderations’ should be moved to a different section since reconsiderations are part of the UM process and not the appeal process.

NMMRA agrees and has made the appropriate changes.

VONM cannot fully respond to this section since the last paragraph appears to be incomplete and we did not receive a revised draft prior to submission of this request for reconsideration.

15. Pages 11 and 12 – Recommendations:

   - Bullets 1, 3, 13 – This recommendation is being addressed. Policy CL203 is being revised and renamed to CL303. The revision is scheduled for presentation to VONM’s Quality Management Committee (QMC) in November 2007; following approval by the QMC, the policy will be presented for approval to the Collaborative’s Oversight Team (OT) at the next scheduled OT meeting. The policy includes the new UM timelines that went into effect on July 1, 2007 and addresses the processes “for timely care coordination referrals after a clinical denial” and “for [the] reconsideration process to occur timely”.

   NMMRA duly notes VONM changes, however, the recommendation being addressed is not during the audit time frame.

   - Bullet 2 (as revised) – This recommendation is being addressed. The recommendation is for VONM to “develop a process to ensure recommended services are authorized timely” As stated above in the item regarding the Authorizations section, while VONM does recommend alternate levels of care (LOC) upon a denial, this does not guarantee that the recommended LOC will be the LOC received or even that the consumer will choose to follow through with receiving services. Therefore, requiring a process for authorizing the alternate LOC recommended will not address the issue of continuity of care.

   NMMRA duly notes VONM changes, however, the recommendation being addressed is not during the audit time frame.

   - VONM is currently addressing this issue as required by the Directed Corrective Action Plan (DCAP) referenced above. Clinical staff does verify whether the alternate LOC recommended is available in the consumer’s area. Pursuant to the DCAP, VONM will be tracking this activity in a monthly report to be submitted to HSD.

   NMMRA duly notes VONM changes, however, the recommendation being addressed did not occur during the audit time frame.
Bullet 4 – Please provide clarification on what is meant by “offering consumers/families an alternative treatment in lieu of or in addition to care coordination services.”

NMMRA duly notes VONM changes, however, the recommendation being addressed is not during the audit time frame.

Bullets 5, 6 and 7 – These recommendations have already been implemented. The Specialized Care Coordination Program policy was revised and approved by the Collaborative’s Oversight Team on 7/2/07, after the audit. The new policy addresses all three of these recommendations; SCCs have been trained on the policy and the program changes have been implemented.

NMMRA duly notes VONM changes, however, the recommendation being addressed occurred after the audit time frame.

Bullet 8 – This recommendation has already been implemented. Policy CL408, Clinical Operations Auditing was approved by OT in June, 2007 and VONM began conducting internal file audits for all clinicians including the SCCs.

NMMRA duly notes VONM changes.

Bullet 9 – This recommendation is already being addressed as part of the DCAP referenced above in the form of a monthly report regarding overturned denials.

NMMRA duly notes VONM changes, however, the recommendation being addressed occurred after the audit time frame.

Bullet 10 – This recommendation is already being addressed as part of the DCAP referenced above.

NMMRA duly notes VONM changes, however, the recommendation being addressed occurred after the audit time frame.

Bullets 11 and 12 – These recommendations have already been addressed by the creation of the Denials Coordinator position and the assignment of oversight of the Denials process to one of the Clinical Supervisors. Process changes have been implemented, including regular internal audits of the denials process using CL303B, Denial Audit Tool, as approved by OT in July 2007.

NMMRA duly notes VONM changes, however, the recommendation being addressed occurred after the audit time frame.

Bullet 14 – This recommendation is being addressed. One of the Quality Improvement Activities VONM is conducting this fiscal year addresses this recommendation and a new process for inpatient follow-up is being implemented on November 1, 2007.

NMMRA duly notes VONM changes.
Conclusion
The BH Continuum of Care Audit was based on 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 VONM earned the following earned designation for the respective MAD standards and contractual requirements for the following scored components:

- Case Review – **Full compliance (96%)**
- Coordination of Services – **Minimal compliance (66%)**

The combined overall score for the BH Continuum of Care Audit is 89% to earn a rating of **Moderate compliance**.

Corrective Action
Corrective action is recommended for areas scoring minimal compliance. Based on the findings, NMMRA recommends corrective action for Coordination of Care.