Focused Clinical Denial Audit of Behavioral Health Services
December 1, 2006 through January 31, 2007

Final Report
April 11, 2007

Prepared by NMMRA for New Mexico Human Services Department and The Interagency Behavioral Health Purchasing Collaborative Under PSC 06-630-8000-02

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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 (VONM) as the SE. Included in the transformation to a single statewide BH system, VONM partnered with the state’s Behavioral Health Purchasing Collaborative in managing the NM publicly funded BH service system.

Required by the SE vendor agreement, VONM 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) as its external quality review organization (EQRO) 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.

NMMRA presented its preliminary audit findings regarding VONM’s performance on clinical and administrative utilization review denials, specifically second-level review cases, (according to Letter of Direction (LOD) 07-09, to NM HSD on January 16, 2007. Shortly thereafter, on January 18, 2007, VONM presented their community reinvestment plan and possible reductions to enhanced benefits to the NM Behavioral Health Collaborative Agency. This meeting also included public input that highlighted a significant increase in Residential Treatment Center (RTC) service denials. Based on these two reports, NM HSD issued Letter of Direction (LOD) No. 07-14 on January 22, 2007 to NMMRA to conduct a focused audit of VONM’s clinical denials for the time period beginning December 1, 2006 through January 31, 2007. 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 and FY 2007 utilization review denial audits. This audit represents VONM’s fourth Utilization Review (UR) Denial Audit conducted by NMMRA.
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 NMAC 8.305.8.13 Utilization Management (UM) regulations.

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

- Utilize MAD 8.305.8.13 B (2)(a)(b) for denials on medical necessity definition
- Correctly identifying expedited appeals for urgent requests
- Relevant clinical information must be included in the charts
- Care coordination referrals 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 residential treatment center (RTC), treatment foster care (TFC) and acute inpatient care recorded denials of BH services for managed care Medicaid consumers during the audit period as reported in Report HSD 2 by VONM to NM HSD. The universe was defined by NM HSD to identify any patterns in clinically related denials. The sample is targeted, non-random.

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 reduce the likelihood that an inappropriate conclusion may be drawn.

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 eligible providers serving the NM Medicaid population
- Representative of the setting types of services; RTC and acute inpatient psychiatric hospital

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1 Report HSD 2 is a detailed denial of services report that includes specifics related to all denied services.
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.

Audit Overview
Approximately two weeks prior to the scheduled audit, January 30, 2007, NMMRA conducted a teleconference with representatives from VONM and HSD. The teleconference provided an opportunity to review applicable rules, regulations, quality standards, and documentation.

On-Site Meeting
NMMRA conducted an opening conference with key personnel from VONM on February 20, 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, 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 one day and was conducted by NMMRA examiners. NMMRA examiners reviewed all cases in the sample and reviewed VONM’s utilization management (UM) policies and procedures governing denials. This included criteria for the use of clinical information, documented criteria and timeliness standards.

NMMRA reviewed 30 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 4.8 was scored, indicating high satisfaction with the audit engagement. Attendees were “highly satisfied” with the audit overview process and preliminary findings documentation provided by NMMRA.
Scoring Methodology

Data provided by VONM, either prior to or during the on-site audit, was the only information considered by NMMRA in determining VONM’s 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 VONM’s performance, NMMRA addressed the following indicators in addition to scoring case-level performance:

- Assessment of consistent applications of VONM’s approved NM HSD level-of-care 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)
- 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 on the next page.

Compliance Levels

Individual case scores were summarized and aggregated, and then a percent overall score was determined and interpreted as described in Table 2 on the next page.
Table 1:

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

Table 2:

<table>
<thead>
<tr>
<th>SE Compliance Levels</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90% - 100% SE has met or exceeded standard</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>79% - 89% 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% 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% 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:

<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 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 10 cases or 33% of the sample. This percentage exceeds NMMRA’s standard of 20 percent to meet reasonable reliability and validity expectations. The higher percentage rate was determined to substantiate 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 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 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: 79 – 89%
  - Minimal Compliance: 60% - 78%
  - Non-compliance: below 60%

- The EQRO Agreement Rate was calculated and assigned using the following designations:
  - Superior: 85- 100%
  - Opportunity for Improvement: 70 – 84%
  - Mandatory corrective action: below 70%

NMMRA conducted three behavioral health utilization review denial audits over the last year. VONM has shown overall improvement on the following areas: timeliness of denial decisions, required components of the denial letter, and notification timeliness. Improvement has been noted in the care coordinators case documentation.

An area of significant concern, noted in the last three audits, relates to the medical directors’ case documentation of the denial decision based on the HSD approved level of care guidelines.

Table 4:

<table>
<thead>
<tr>
<th>Review Period</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 Score</td>
<td>Score</td>
<td>Score</td>
<td>Score</td>
</tr>
<tr>
<td>Case Review Points</td>
<td>355 out of 368</td>
<td>96%</td>
<td>99%</td>
<td>84%</td>
</tr>
<tr>
<td>EQRO/SE Agreement Clinical</td>
<td>25 out of 30</td>
<td>83%</td>
<td>79%</td>
<td>83%</td>
</tr>
</tbody>
</table>
Case Review
VONM scored 355 points out of a possible 368 points, and earned a rating of Full Compliance in Case Review. VONM scored 77% in the Case Documentation Criteria category and earned a rating of Minimal Compliance. The score for this category was driven by the medical director not referencing criteria in the file documentation. NMMRA examiners noted that VONM has not addressed recommendations made in prior audits, such as the implementation of a medical director IRR process and file documentation requirements. Furthermore, NMMRA examiners noted that documentation of services was absent in the files. Although the score reflects VONM has made improvement in its written processes, the organization continues to struggle with timely clinical care decisions, case documentation of denial decision with supporting criteria documentation and documentation of alternative services provided after denied benefits.

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

Agreement Rate on Denial Decisions
NMMRA audited 30 cases for Clinical Review. VONM scored 83% in the Agreement Rate on Denial Decisions for Clinical Review and received a rating of Opportunity for Improvement for this measure. Following NMMRA’s first level review, six cases were sent by NMMRA’s examiners to second-level review because NMMRA examiners disagreed with VONM’s denial decisions. The second-level reviewer(s) agreed with NMMRA’s disagreement opinion on five of the six cases. All of these cases were residential treatment center (RTC) pre-certification requests. The EQRO Disagreement with SE Denial Decision is included in Appendix 3.

NMMRA examiners also identified that an additional six, or 20%, of the UR denials within the audit sample were originally denied by VONM and later overturned by VONM’s second-level appeal process. The percentage of cases VONM overturned in its internal appeal review process, one in five reported in the audit sample, appears to be very high. Upon review, HSD has concerns about this finding, as it may relate to ongoing physician IRR issues.

The completed audit tools for the cases that NMMRA disagreed with VONM’s denial decisions are included in Appendix 4. No suspected fraud and abuse was identified.

Prior to the on-site engagement date but after the LOD for this review, NM HSD directed NMMRA to review care coordination services when a service was denied by VONM. Based on this direction, NMMRA examiners identified the following BH care coordination concerns. Half of the consumers in the audit sample experienced referral delays, up to two months, for specialized care coordination, and a significant number of the consumers received no BH services after receiving a denied benefit decision when residing in detention, foster care or home settings.

Shortly after this audit, HSD requested from VONM specific information and follow-up on 15 cases.
Recommendations

Subsequent to the previous behavioral health utilization review denial audits, NMMRA has provided VONM recommendations for improvement in the final audit report. This has been done to help facilitate continuous quality improvement of behavioral health care provided by VONM. Full compliance for each standard should be both the goal and the expectation, as the standards are well-delineated by NM HSD.

Upon review of the behavioral health utilization review 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:

- Develop and implement a medical director IRR process to ensure appropriate level-of-care referrals. (This is the third time NMMRA has identified this issue)
- 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 & #3”
- Document verbal denial decisions by the medical director with the specific criteria cited as directed
- Conduct an internal audit on the frequency and type of denial decision cases that are overturned on second level review
- Correct denial letters to document the appropriate MAD reference for the denial decision. For example the denial decision should state “does not meet medical necessity,” “lack of prior auth,” or “not a covered benefit”
- Develop a policy and procedure for care coordination referrals after a clinical denial decision has been made by the medical director to include the following:
  - Timeliness of referral;
  - Appropriateness of referral;
  - Process for offering consumers/families any alternative treatment in lieu of or in addition to care coordination services;
  - Process how VONM staff are trained on resources and resource availability statewide; and
  - Process on how follow-up care is monitored following a referral for care coordination

NMMRA presented preliminary audit findings to NM HSD on March 16, 2007, and as a result NM HSD has recommended that a second focused denial audit be conducted for VONM to include the additional following areas: consistent documentation by the medical director of the criteria used on all clinical denials, management of clinical denials within VONM and the use of care coordination or alternative services offered, current authorizations, grievance, appeals, and fair hearings.

Based on the 77% minimal compliance score within the Case Documentation, NM HSD will request from VONM a detailed corrective action plan (CAP) addressing how improvement will be made to physician documentation of specific criteria for all clinical denial decisions.
Reconsideration Review
VONM reviewed the preliminary findings of the BH UR Denial Draft Audit Report and was provided an opportunity to respond with specific questions, comments and requests. No additional evidence was submitted by VONM as April 11, 2007 and VONM replied in writing to NMMRA “as in agreement” with the report findings.

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 VONM earned the following designation for the MAD standards and contractual requirements examined:

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

Regarding the case review process components of the audit, HSD has identified specific actions required by VONM which are included in this report.

Regarding the agreement rate on denial decisions component of the audit, “Opportunity for Improvement” is identified. This may relate to the lack of consistent application and/or documentation of State approved level of care criteria by the Medical Director.