Provider Reference Guide

Methodology for Behavioral Health Intake Medical Record Audits

Contract year October 1, 2019-September 30, 2020

Introduction:
Under the AHCCCS ACC and RBHA contracts, all health plans are required per AHCCCS Medical Policy Manual (AMPM) Chapter 900, Policy 910, Attachment 910A and Policy 940 to monitor contracted behavioral health mental health outpatient clinics – provider type 77, integrated clinics – provider type IC and federally qualified health clinics – provider type C2 that conduct behavioral health intakes for members on an annual basis per contract fiscal year (October 1st – September 30th). All health plans utilize a collaborative and transparent audit process in conjunction with the Arizona Association of Health Plans (AzAHP), which results in only one medical record being completed by an assigned health plan and lessens provider burden. Medical record reviews will be conducted utilizing a provider's electronic medical record (EMR) where applicable to further lessen provider burden. This collaborative methodology and audit process is conducted at the provider level and is outlined below.

1. Sampling:
   - A maximum sample of 30 member medical records at the provider level will be reviewed with a 15 medical record oversample to be utilized if available at the discretion of the assigned health plan for replacement reasons (member record closed for more than 6 months, etc.). Health plans want to ensure that we are reviewing the provider's most current processes and member service delivery.
   - If an assigned health plan has less than 30 members in the audit review period, the entire population will be audited.
   - The assigned health plan will only be reviewing their own members for the sample.
   - Sampling will be based on the assigned health plan's claims data and provider's tax identification number (TIN). A member must have had at least one behavioral health covered service in the review period to be eligible for review.
   - Medical record reviews will be conducted utilizing a stratified random sampling method that is representative of the provider's member population and region(s) in which the provider is contracted with the assigned health plan conducting the review. If a contracted provider serves both adults and children, the assigned health plan's sample will include a maximum of 15 Adults and 15 Children
     - ACC Health Plan sample at a minimum must include when applicable:
       - Adults: 18 Years and Older
       - Children: Birth – 18 Years
       - CRS Designation: Birth – 21 Years
       - Members identified with Substance Use & Medication Assisted Treatment (MAT)

        - Members on Court-Ordered Treatment (COT)
    - RBHA Health Plan sample at a minimum must include when applicable:
        - Children identified as DD/LTC
        - Adults identified as DD/LTC
        - Children receiving services under the Comprehensive Medical Dental Plan (CMDP)
        - Adult Members identified with a Serious Mental Illness (SMI)
        - Members identified with Substance Use & Medication Assisted Treatment (MAT)
        - Members on Court-Ordered Treatment (COT)

- Audit Calendar:
    - One Health Plan will be assigned per year to complete the audit.
    - The Health Plan assigned will change each contract year so the provider is not reviewed by the same health plan year after year.
    - Mercy Care may need to complete focus audits throughout the year based on identified need (e.g., AHCCCS CAP).

2. Audit Notification:
    - Assigned health plans will be responsible for notifying a provider of their scheduled audit at least 2 weeks prior to the start date either by secure encrypted email or letter.
    - At a minimum, the provider CEO and appropriate provider staff will be notified of the annual audit
    - Audit review period will be one year back from the date the notification is sent. Example: if the notification sent to the provider on 4/1/19, the audit review period will be 4/2/18 – 4/1/19.
    - Audit notification at a minimum must include:
        - Start and End Date of the Audit
        - Sample and Over Sample List, if applicable
        - AHCCCS Audit Tools & Operational Definitions applicable to the Audit Sample
        - Audit Review Period
        - Reviewer Name, email, and credentials

3. Provider Audit:
    - Medical record audit data will be recorded daily on records reviewed by the assigned health plan quality management staff in either a secure web portal or SharePoint system.
    - Formal exit interview will be conducted by the assigned health plan QM staff at the end of the scheduled provider audit in which areas of strength and areas requiring improvement will be discussed. Technical assistance will be provided in reference to any of the individual standards of the audit tool(s) that did not meet the minimum performance standard (MPS) of 85%.
    - A representative from each health plan will be invited to attend the exit meeting regardless of the plan that completed the ACC audit process. Mercy Care will be attending the exit meetings to gain a better understanding of the strengths and opportunities for improvement. By attending these meetings, it will assist in the betterment of our quarterly debriefing process in providing training and technical assistance.
    - A summary of the technical assistance provided will be sent by secure encrypted email to the provider staff and associated health plans at the end of the provider's exit interview.
    - Final audit results will be sent by the assigned health plan within 30 days of the provider's exit interview to ensure all data entered is accurate and will include all associated health plans

contracted with the provider for their records. Member protected health information (PHI) will be removed prior to sending to the associated health plan(s).

- A provider's first initial annual audit for the contract year October 1, 2019-September 30, 2020 will be a baseline review and no formal corrective actions will be administered by the assigned health plan.

Proprietary