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health options

Provider Treatment Record Review Training

November 2021

Chapter

01

Treatment Record Review Overview

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Documentation is not the reason we go into healthcare, but it is an important component

Professional Associations and Accrediting Organizations Code of Ethics outline documentation standards for providers

Documentation requirements are a contractual obligation (included in Beacon's Provider Manual)

Licensed Clinicians often perform chart reviews and work with providers on documentation and expectations

Treatment Record Reviews are one of the tools Beacon uses to ensure quality of care

Proper documentation is necessary to ensure client safety and continuity of care

Healthcare 101: If you didn't document it, it didn't happen

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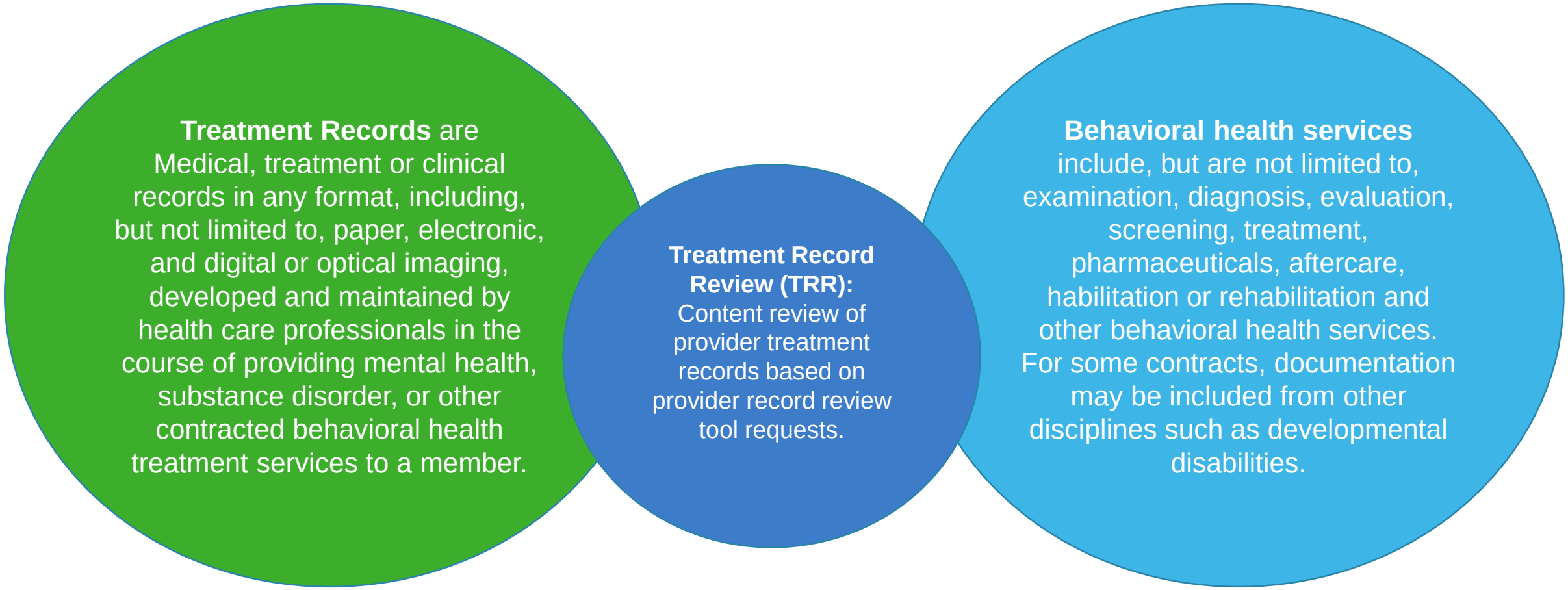
Proper documentation is a critical piece of sound clinical practice



The Treatment Record Review (TRR) Tool provides a framework to evaluate provider quality and compliance

Questions from the TRR were formulated from these source materials:

The **National Committee for Quality Assurance (**NCQA) is an independent, non-profit, evidenced-based accrediting organization that sets the standards for high quality in healthcare. The NCQA accredits organizations ranging from health plans including HMOs and PPOs to physician networks and medical groups.

Similar to NCQA, the **Utilization Review Accreditation Commission** (URAC) is a Washington DC-based healthcare accrediting organization that establishes quality standards for the entire healthcare industry.

Beacon has adopted a number of **Clinical Practice Guidelines** published by the APA, AACAP, and other professional organizations, to guide best practices in the delivery of healthcare for Beacon members. These Clinical Practice Guidelines can be found on Beacon's Provider website: https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-practice-guidelines

Beacon's **Provider Handbook** outlines the Beacon Health Options, Inc. (Beacon) standard policies and procedures for individual providers, affiliates, group practices, programs, and facilities. Beacon's Provider Handbook can be found on Beacon's Provider website: https://www.beaconhealthoptions.com/providers/beacon/handbook/

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Chapter

02

Treatment Record Review (TRR) Process

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The TRR process from start to finish is simple

Record Requests:

- The record request will be sent to you via **fax or encrypted email** (following Anthem policy on emailing PHI).
  - *US Mail* is only used when there is not an electronic communication available for the provider.
- Providers have the option of selecting a virtual review or a desktop review.
  - *For Virtual Reviews*, a Licensed Clinician from Beacon will call to schedule the review.
  - *For Desktop Reviews*, Medical Records are due back to Beacon within 10 calendar days of receipt of notice.
- Licensed Clinician will complete review within 30 calendar days from receipt of the records.
- You will receive an email with the results of the audit within 14 calendar days of the audit being completed.

Routine site visit/virtual visit reviews are requested by Beacon at least (5) five business days prior to the scheduled review date.

Urgent reviews are requested by Beacon at least one (1) business day prior to the scheduled review date (for site visits/virtual visits).

Providers are given the option of having a desktop audit or virtual audit

Virtual Audit

- If your practice uses an electronic medical record (EMR) that has capability for a guest user, our clinicians are able to perform a virtual audit.
- If you choose this option a Licensed Clinician will call to schedule an appointment to review the charts with you electronically.

Desktop Audit

- If you choose a desktop audit, copies are made of the member files and sent to Beacon via encrypted email or secure fax.

Performance Improvement Plans may be required if a provider scores below 80%

Performance Improvement Plan is a collaborative process between Beacon and the provider to improve documentation that does not meet quality standards

If a provider scores below 80% Beacon will request an improvement plan within 10 calendar days of notification of the scores

Beacon will provide training and technical assistance to the provider as needed and request a re-review of the provider within 90 days to determine if improvement has been made

Chapter

03

Review of TRR Tool

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Treatment Record Review Tool

Overview

- Treatment record reviews are performed on a regular basis to ensure that Beacon Health Options (Beacon) **members are receiving safe, evidenced-based, high-quality care**.
- The tool used for provider record reviews is **proprietary and developed by Beacon specifically for in-network providers.**
- The tool assesses provider documentation from assessment to discharge, and the framework is based on **accreditation standards, clinical practice guidelines, and best practice in behavioral health and substance use disorder treatment.**

Section A: Documentation

Member treatment records should be maintained in a manner that is **current, comprehensive, detailed, organized and legible** to promote effective patient care and quality review.

Rationale for why questions in this section are monitored

Beacon's policies and procedures incorporate standards of accrediting organizations to which Beacon is or may be subject (e.g., NCQA and URAC), as well as the requirements of applicable state and federal laws, rules, and regulations.

- Rights and Responsibilities (RR1): Statement of Members' Rights and Responsibilities; URAC CORE v4.0 (C-CPE 2-1) (previously CORE 37 in CORE v3.0).
- Consumer Safety and best practice (could be tied to URAC CORE v4.0 (C-CPE 3-3) (previously CORE 38 in CORE v3.0)

Suggestions for meeting the standard

Member Rights and Responsibilities - part of the consent form packet:

- Evidence provider has a member rights and responsibilities policy that was provided to member (web-based, paper-based, email).
- Part of a checklist of other documents member received upon admission, signed by member to acknowledge receipt at the bottom.
- A separate document acknowledging receipt of member rights, signed at the bottom by member.

Medication, allergies, and medical history - part of the Intake Assessment or Comprehensive Assessment:

- Some providers place allergies at the top of assessment with demographic information.
- If there are no known allergies, documenting NKA is sufficient, but question must be easily identified in the record.

Section B: Continuity and Coordination - OP to OP

As part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral healthcare and treatment of a member. Subject to any required consent or authorization from the member, **participating providers should coordinate the delivery of care of the member with these additional providers.** All coordination, including PCP coordination, should be documented accordingly in the member treatment record. Beacon consent forms are available through the website.

Rationale for why questions in this section are monitored

Care Coordination (CC1): Coordination of Behavioral HealthCare (NCQA)

Suggestions for meeting the standard

- Intake Assessment of Comprehensive Assessment should ask about member's treatment history.
- Scored only if the other OP treatment provider is still actively providing services or has provided services within the preceding 6 months, otherwise N/A.
- If providers are within the same agency or connected to the electronic record, credit is given.
- A fax confirmation or email showing that the information was sent.
- Demonstration that any additional services after the initial assessment were shared.
- Could be documented in a Contact Note, Discharge Summary, Treatment Summary, Treatment Plan, Case Consultation Note, or Progress Note.
- Signed Release of Information or Consent to Obtain Information or documentation that member refused to sign authorization for other MH providers when required due to Health Insurance Portability and Accessibility (HIPAA) restrictions (i.e., genetic information, HIV status, or SUD). HIPAA allows provider to have contact with other treating providers without a Release of Information (ROI). **An ROI without any documentation that communication was attempted and/or occurred does not receive credit for this standard.**

Section C&D: Continuity and Coordination - OP to PCP

As part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral healthcare and treatment of a member. **All coordination, including PCP coordination, should be documented accordingly in the member treatment record.** Beacon consent forms are available through the website.

Rationale for why questions in this section are monitored

NCQA Standard CC2: Collaboration Between Behavioral Healthcare and Medical Care

- The organization collaborates with relevant providers and uses information at its disposal to coordinate behavioral healthcare and medical care and to measure the effectiveness of these actions.
- Whole health, treating the whole person from medical AND behavioral health perspectives.

Suggestions for meeting the standard

- Minimum evidence to demonstrate coordination of care with a PCP would be a signed and dated ROI in the chart or other documentation that communication occurred between provider and PCP. **An ROI without any documentation that communication was attempted and/or occurred does not receive credit for this standard.**
- Communication - Contact Note, Discharge Summary, Treatment Plan, Case Consultation Note, etc.
- The use of an integrated medical record system that is accessible by multiple providers is suffice for this measure.
- Document member refused authorization to speak with PCP.
- Signed Release of Information or Consent to Obtain Information to sign authorization for other MH providers when required due to Health Insurance Portability and Availability (HIPAA) restrictions (i.e., genetic information, HIV status, or SUD). HIPAA allows provider to have contact with other treating provider without ROI if there are not restrictions described previously.

Section E: Clinical Practice Guidelines

CPGs are written documents generally developed by professional organizations that establish standards backed by strong scientific evidence. Beacon adopts both CPGs (**scientifically based by research**) and clinical practice resources (**backed by consensus of subject matter experts**) annually. Beacon encourages our credentialed providers to view the adopted guidelines below and incorporate into your practice as appropriate.

Rationale for why questions in this section are monitored

NCQA standard QI 9 requires accredited managed behavioral health organizations (MBHOs) to adopt at least two adult and one child/adolescent CPG each year. In addition to the adoption of at least three clinical practice guidelines, MBHOs are required to measure provider performance against the adopted standards.

Beacon will promote the use of three clinical practice guidelines related to the diagnosis of Attention-Deficit/Hyperactivity Disorder and Schizophrenia and which are prevalent conditions in the Beacon membership. The third CPG is related to practice guidelines for the psychiatric evaluation of adults.

Suggestions for meeting the standard

Clinical practice guidelines and resources are audited when applicable. Considerations for auditing, including diagnosis and age requirements, must be met to be included in the audit.

For 2022, the following HEDIS® measures will be used to monitor adherence to the clinical practice guidelines:

- Follow-Up Care for Children Prescribed ADHD Medication (ADD),
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA),
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) and
- Follow-Up after Hospitalization for Mental Illness (FUH).

Section F: Targeted Clinical Review

In addition to other requests for member treatment records included in the provider handbook and/or the provider agreement, member treatment records are subject to targeted and/or unplanned reviews by the Beacon Quality Management Department or its designee, as well as audits required by state, local, and federal regulatory agencies and accreditation entities to which Beacon is or may be subject.

Rationale for why questions in this section are monitored

Quality Improvement (QI) 8 Element I: Case Management-Ongoing Management.

Suggestions for meeting the standard

- Records are reviewed by licensed clinicians, and some sections/questions require use of clinical judgment.
- A DSM (or the most current version of the DSM) diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.
- Short-term is defined as six months or less. **Exception:** if the length of time in treatment is less than 90 days and there is evidence of a working treatment plan in the progress note or other document, then credit is given. If the length of time is greater than 90 days in treatment and there is no formalized treatment plan, a score of NO is given.
- **In MA only**, evidence that an outcomes tool was used in determining the member's treatment plan is required; otherwise a score of YES or N/A is given.

Section G: Telehealth Member Safety

Telehealth questions were added to the treatment record review tool in 2021 in response to the increased use of telehealth for the delivery of services by behavioral health providers. Part of Beacon's overall member safety program is to ensure best practice related to ensuring that established telehealth standards are followed.

Rationale for why questions in this section are monitored

NCQA will issue standards in 2022, in lieu of specific accreditation standards. Beacon is monitoring select areas of telehealth delivery related to **member safety** and **best practice** with established guidelines. The telehealth questions are focused on treatment efficacy (modality type), member location (if EMS is needed), and continuity of care if session is interrupted due to technical issue.

Suggestions for meeting the standard

Documentation in the progress or contact note should include:

- Modality of telehealth session (video or phone only),
- Member's physical location at beginning of session, and
- Technical difficulty and mitigation.

Clear documentation of type of session (video or phone), member location, and if there was a technology issue, how it was mitigated and whether the session was continued or rescheduled, will yield full credit on this section.

Frequently Asked Questions

1. **Many Federally Qualified Health Centers (FQHCs) sites have integrated electronic medical records (EMRs), so their clinicians can see notes from the PCP, psychiatrist, etc. What do providers need to document to illustrate that there is collaboration of care since the providers are reviewing notes from the PCP and psychologist and communicating through the EMR?**

   If the provider has a fully integrated EMR then this requirement is met and provider is given credit. Our recommendation for best practice is for the provider to document in a progress note or communication log that physical health issues were reviewed.

2. **Why is collaboration of care with the PCP important?**

   As many medical symptoms have underlying psychological factors and vice versa, open communication and collaboration among mental health professionals and PCPs have been found to reduce clinical errors, improve patient health status, and enhance the quality of patient care, while leading to better patient treatment compliance and enhanced satisfaction.

3. **What is the purpose of inquiring about medical diagnosis if we are not treating medical diagnoses?**

   A thorough assessment of the member's medical history and current medical diagnosis are important to rule out any underlying medical causes that may be contributing to the member's symptomology. In addition, a member's current symptoms may be related to an undiagnosed medical condition that is associated with the member's medical history. It is important that we are assessing the whole person's needs and making appropriate referrals when necessary.

Frequently Asked Questions

4. **Why do I need to document if the session was via phone or video? Can you just look at the claims code?**

   There is not a modifier code that distinguishes between video or phone only. Claims data could not provide this information in its current state. In the future, if CMS or another regulatory body issues a modifier code, we will be able to pull from claims, but this option does not exist today. The only way we can capture this information is from reviewing the member's treatment record.

5. **What is meant by a treatment plan using measurable and short-term goals?**

   Generally, goals will have a duration of no more than six months, at which point a Treatment Plan Review is completed to assess progress, and goals are modified. Goals should be broken down in short-term increments that are achievable within this timeframe. Measurable goals/objectives allow the clinician and the member to assess progress more easily. An example of this would be: the member will incorporate three new coping techniques to address symptoms of anxiety within the next six months.

6. **What is a cultural/linguistic assessment?**

   At a minimum, a cultural/linguistic assessment will ask the member their language preference, but this type of assessment also includes questions about country of origin, racial/ethnic identity, cultural practices, spiritual beliefs, gender identity, sexual orientation, etc. Cultural competence in mental health service delivery indicates that all of the factors that make up the whole person are taken into consideration. A culturally competent healthcare system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.

Frequently Asked Questions

7. **Do you match the claims with progress notes to confirm that a note was completed for each session?**

   No, we are not auditing claims, only the treatment records.

8. **What happens if we do not pass? Will I be kicked out of the network or have to pay back money? Do I have to amend the charts that were audited and resubmit those charts?**

   This is a collaborative activity to promote best practice in documentation standards; the intent is not to penalize or impact your in-network status. If a provider scores below 80 percent, they will be put on a Corrective Action Plan (CAP) to improve documentation. Beacon may re-audit after the provider has opportunity to implement new practices. Beacon does not require providers to amend audited records and would recommend the provider follow established policies/procedures related to documentation requirements.

9. **Can Beacon provide me with a copy of your telehealth policy?**

   Beacon recommends that the practitioner follow professional association guidelines for telehealth best practice. Beacon has adopted four guidelines for the practice of telehealth that can be found on Beacon's Provider website here: https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-practice-guidelines/

Additional Resources are available for providers

Section A: Documentation

Page 26, Section 8.01 **Member Rights and Responsibilities** in the Provider Handbook:
https://www.beaconhealthoptions.com/wp-content/uploads/Beacon-Provider-Handbook.pdf

Page 73-74, Section 13.09 **Treatment Record Standards and Guidelines** in the Provider Handbook:
https://www.beaconhealthoptions.com/wp-content/uploads/Beacon-Provider-Handbook.pdf

Section B: Continuity and Coordination – OP to OP

Pages 31-32, Section 9.04 **Coordination with Primary Care/Treating Providers** in the Provider Handbook:
https://www.beaconhealthoptions.com/wp-content/uploads/Beacon-Provider-Handbook.pdf

Use a standard form to share information. You can use your own or one of the two versions available for free on Beacon's website:
https://www.beaconhealthoptions.com/providers/formsand-resources/

Section C & D: Continuity & Coordination – OP to PCP

Pages 31-32, Section 9.04 **Coordination with Primary Care/Treating Providers** in the Provider Handbook:
https://www.beaconhealthoptions.com/wp-content/uploads/Beacon-Provider-Handbook.pdf

Use a **standard form** to share information. You can use your own or one of the two versions available for free on Beacon's website:
https://www.beaconhealthoptions.com/providers/login/

Page 79 of The American Psychiatric Association Practice Guidelines For The Psychiatric Evaluation of Adults → **GUIDELINE VI.** *Assessment of Medical Health* (includes: *Review of Supporting Research Evidence*):
PsychEval.book (psychiatryonline.org)

Additional Resources are available for providers

Section E: Clinical Practice Guidelines

Practice Guideline for the Treatment of Patients with Schizophrenia – Third Edition
ADHD Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents
Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition

Section F: Targeted Clinical Review

If Beacon identifies that fraud, waste, or abuse has occurred based on information, data, or facts, Beacon must immediately notify relevant state and federal program integrity agencies following the completion of ordinary due diligence regarding a suspected fraud, waste, or abuse case.

Beacon's Code of Conduct and Ethics can be found on the provider website: https://s21151.pcdn.co/wp-content/uploads/Beacon-Health-Options-Code-of-Conduct.pdf

Section G: Telehealth Member Safety

American Psychological Association (APA) Guidelines for the Practice of Telepsychology
American Psychiatric Association (APA) and American Telemedicine Association (ATA) Best Practice in Videoconferencing-Based Telemental Health
American Academy of Child & Adolescent Psychiatry (AACAP) Telepsychiatry Toolkit
National Association of Social Workers (NASW), Association of Social Work Boards (ASWB), Council on Social Work Education (CSWE) and Clinical Social Work Association (CSWA) Standards for Technology in Social Work Practice

Thank You

Contact Us

National Provider Line: 1-800-397-1630

www.beaconhealthoptions.com

If you would like to obtain a copy of the Provider Tip Sheets, they are availabe here: Treatment Record Reviews | Beacon Health Options