Section 14

QUALITY MANAGEMENT

ValueOptions Colorado supports the quality management programs of Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership, all of which are Behavioral Health Organizations (BHOs) contracted with the state of Colorado for the Medicaid Community Mental Health Services Program. Each of the BHO's Quality Management Programs monitors and evaluates quality across the entire range of services provided to Medicaid members. The BHO's QM programs are intended to ensure that the structure and processes in place lead to desired outcomes for members.
The scope of the QM Programs includes:

- Clinical Services/Utilization Management (UM) Programs;
- Care Process and Outcome Measurement/Monitoring for Members in Treatment;
- Clinical Treatment Record Evaluation;
- Service Availability and Access to Care;
- Quality of Care and Patient Safety/Adverse Incident Evaluation;
- Program Integrity/Fraud and Abuse;
- Compliance with all applicable Federal and State regulations in the delivery of services to members.
- Performance Improvement Activities/Projects

Several of the above activities and processes are described in greater detail in other sections of the Provider Handbook.

For more information or to ask questions about specific BHO's Quality Management Programs, contact the Director of Quality Management for the BHO located in your area. More information about individual BHO Quality Management Programs can be obtained by referencing the BHO specific provider addendum reference guides and the respective BHO website.

PROGRAM INTEGRITY OVERVIEW

The BHOs and ValueOptions are responsible to the State of Colorado for overall program integrity in the delivery of services to members. The BHOs and ValueOptions are required to investigate any reported or suspected allegations of fraud and/or abuse. Colorado program integrity activities include:

- Review of alleged illegal, unethical or unprofessional conduct;
- Duplicate payment prevention;
- Treatment record audits verifying services billed are documented in member record, and that documentation includes all required elements;
- Investigation of suspected, reported or alleged fraud or abuse;

Providers are expected at all times to bill only for medically necessary authorized services delivered to members with a covered diagnosis. You may bill only for the authorized services that you provide. Every service provided to a Medicaid Member must have a corresponding note in the medical record documenting the treatment provided, or a refund of the payment for

the service will be required. Treatment reflected in the progress note must be tied to the treatment plan. As required by state and federal regulations, suspected cases of fraud or abuse are reported to the State of Colorado Department of Health Care Policy and Financing and the Medicaid Fraud and Abuse Unit immediately upon discovery. Following a fraud or abuse investigation, if allegations are supported, follow-up actions may include implementation and monitoring of corrective actions, recovery of any payments for undocumented services, termination from the ValueOptions network and/or referral of the case to appropriate governmental agencies. For more information on documentation requirements, refer to Section XIX Documentation Requirements.

REPORTING ADVERSE INCIDENTS (VARIANCES/SENTINEL EVENTS)

To manage care effectively and assure the safety of members, the BHOs and ValueOptions investigate and review adverse incidents that have resulted in harm or potential harm to a member or significant other participating in treatment. You are required to complete a report on the following adverse incidents, to be submitted to ValueOptions Colorado:

- Attempted or completed suicide or homicide at any level of treatment
- Death, by any cause, while in psychiatric treatment
- Allegations of sexual or physical abuse or neglect
- Assaults with physical harm in which the Member is the initiator or victim
- Absence without leave, AMA, or missing and considered a danger to self and/or others; and/or endangered and unable to care for self
- Breach of confidentiality by staff
- Accidental injuries either in a facility or provider office
- Medication errors/Adverse drug reactions
- Other variances inconsistent with routine patient care

Providers are expected to report incidents on an Adverse Incident Report Form, included as an attachment to this section, within 24 hours of the occurrence for sentinel events (e.g., unexpected deaths, suicides, homicides), and within 48 hours for all other incidents. Please fax this completed form to ValueOptions Quality Management Department at (719) 538-1456. Depending upon the type of incident and the circumstances, you may be contacted for further information or a review of the incident.

BHO PROVIDER QUALITY PROGRAM (PQP)

The objective of the BHO and VO's Provider Quality Program (PQP) is to assess and improve the quality and effectiveness of care delivered to Colorado Medicaid members. The program is designed to quantify provider performance so data can be used to recognize quality care, identify provider and facility best practices, improve provider network services, and identify areas for continuing education. Multiple measures of member satisfaction and outcome as well as practitioner practice patterns are reviewed. Other areas reviewed include Member satisfaction with their provider, treatment record documentation, compliments, grievances, and quality of care and utilization patterns.

QUALITY OF CARE

The BHOs have a joint Quality of Care Committee that oversees the investigation and resolution of all quality of care issues. Please contact the BHO Quality Management Department to report

any quality of care issues identified in the provision of services to members. Potential quality of care indicators, monitored by the BHOs and ValueOptions include the following types of quality of care issues:

- Provider inappropriate/unprofessional behavior
- Clinical practice-related issues
- Access to care-related issues
- Attitude and service-related issues

Providers are required to respond to Quality of Care inquiries, assist with investigations, provide corrective action plans when requested, and report on progress toward addressing concerns through corrective actions as requested.

Treatment Record Audits

ValueOptions, on behalf of the BHO's, may request treatment records for documentation reviews, quality of care reviews, state Medicaid audits or reviews verifying that services billed are documented in member's treatment record and include all required elements. As a ValueOptions provider, you are expected to comply with all requests for member treatment records as specified in your contract (Section 2, Compliance with ValueOptions Policies and Programs).

CONFIDENTIALITY

To support quality management responsibilities for oversight of member care, all BHOs and ValueOptions have in place strict confidentiality policies and procedures regarding the protection and disclosure of member information. These policies and procedures ensure that all protected health information (PHI) providers submit is maintained on a confidential basis in accordance with all applicable regulatory (e.g. HIPAA) and accreditation requirements. The BHOs and ValueOptions ensure that all such information obtained is used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment. In addition, ValueOptions maintains information systems to collect, maintain, and analyze information that incorporate adequate safeguards to ensure the confidentiality and security of PHI received, as well as a plan for secure storage, maintenance, tracking and destruction of member-identifiable clinical information.

BHO and ValueOptions staff engaged in quality improvement activities maintain the confidentiality of the information used in such activities. All written reports, records or any work product or communication related to quality improvement activities are considered privileged and confidential information, except when specific reference is necessary to meet the goals of the QM program. Reference to individual providers or members is redacted to safeguard the person's identity. Confidential information used in QM activities may include but are not limited to:

· Protected Health Information (PHI);
· Certification of mental health treatment;
· Claims processing information;
· Utilization review;
· Peer review;
· Response to congressional inquiries (made at the request of the member);
· Appeals; and

·Quality assurance

Providers and delegated entities are expected to safeguard the confidentiality of treatment record information related to both active and past clients. Participating provider contracts are explicit in regard to treatment record confidentiality requirements.