Behavioral Health Partnership Oversight Council Operations Subcommittee

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Meeting Summary: October 19, 2007

Co-Chairs: Lorna Grivois & Stephen Larcen

Upcoming meeting dates: Friday Nov. 16, Dec. 14 @ 2:30 PM CTBHP/VO

CTBHP/VO Report *(Click on icon below to view presentation)*

Operations October 19-2007 final.ppt

Discussion highlights related to the report:

- ✓ Lori Szczygiel (ValueOptions – CTBHP/VO) stated the result of the efficiency endeavors for IOP/EDT authorization timeline changes implemented October 1, 2007 is 1-2 less CCRs per provider per client.
- ✓ Concurrent Review (CCR) average call time-34 minutes. CTBHP/VO commented that several factors influence this: new staff in training and more robust documentation recommended in the State Mercer review of the ASO, targeting medical necessity. Karen Andersson (DCF) said there is a balance between the ASO contractual provisions and the design of medical necessity and family centered, cultural competency of the BHP program. Stephen Larcen asked if random review of CCRs would provide a quality evaluation based on a standard of care by the provider. CTBHP/VO offered that the CCR process, based on level of care standards (approved by the BHP OC) can serve as a prompt for behavioral change.
  - After Round 2 testing of CCR within the web registration system, VO anticipates web availability by mid-November 2007.
  - Approximately 150 BHP providers, some of which are facilities but mainly independent providers currently do not use the web system for registration. May be due to practice resources or comfort level with the system.
- ✓ VO has a new Intensive Care Management (ICM) Director and after training, 3 new clinical care managers hired in September will assume ICM functions.
- ✓ CCMC ED Autumn volume increase has led to re-implementation of the BHP support initiatives that were initiated 9/24/07. The CCMC/IOL CARE 6 bed unit opened October 15. The unit's goal is to divert pediatric psychiatric patients from the CCMC ED to the unit for a 3 day evaluation/stabilization then referral to community-based care or direct hospital admission as appropriate. If the unit is full, patients would have to go to the ED.
- ✓ Local Area Development Plans (LADP) final reports were submitted to BHP September 25, 2007 and an executive summary of program development and expansion needs is being developed with reconciliation of local area office identified gaps and ASO geo-mapping system differences. The reports were reviewed by the BHP and the CTBHP/VO is waiting for feedback. Questions were raised about Region 5 capacity; comments:
  - Loss of a psychiatric residential treatment facility (PRTF) WellSpring in Region 5.(*The OHCA report recommended "an increase in the number of acute care general hospital and/or psychiatric beds and PRTFs in Region 5" based on recommendations of an implementation group convened by OHCA).*

- In 2006 OHCA provided data specific to Region 5 and an RFI was released focusing on inpatient services with updates on service demand in that area. Find the initial 2006 report at: http://www.ct.gov/ohca/lib/ohca/publications/acute_care_pediatric_behavioral_health_services.pdf
- In addition each area DCF office in Region 5 is collecting specific data which can be shared with the Subcommittee and Council.
- Dr. Larcen recommended updated information related to Region 5 be brought to the BHP OC as part of the system of care. CTBHP/VO stated the executive summary of the LADP will look more closely at identified gaps in Region 5. This data will be brought back to Region 5 providers for review and strategy planning.

✓ BHP was asked to identify 1) quality indicators within the information gathered in the pre-cert, CCRs and 2) extension plans for web-based CCR to other services and costs of these levels of services.

BHP Claims *(click icon below to view presentation)*

Denial Reports.xls

Paul Piccione (DSS) reviewed the claims denial reports (28.15% denied this claim cycle 9-25-07); the top denial reasons and an example of proposed denied claims report by provider. Discussion points:

✓ Hospital outpatient clinics and mental health clinics have the largest number of the denied claims. Clifford Beers clinic has seen an improvement in billing/reimbursement over the last two months with the new billing service. While resolution of chronic administrative claims denials is up to the provider that may have worked with the BHP Rapid Response Team, it was suggested that BHP/DSS include claim error reduction strategies in the training for the new Medicaid billing system that is expected to be implemented late 2007.

✓ November meeting, the Subcommittee will look at claims reports, identify what needs to be altered, how TPL claims may affect timely filing and consider what a reasonable denial threshold is.*

✓ The TPL (Medicaid as payer of last resort) claims work group will provide information to the SC about the issues that delay processing and cause denials.

*From Paul Piccione (DSS) that was sent to the SC with a copy of the above claims report:

In addition there is the 'report card' that shows denials reasons sorted by provider specialty that I have episodically shared. This month it was revised to eliminate the misleading denial reasons that occur with FQHC claims and to add two columns. One shows the total number of claims details submitted by each provider specialty during that cycle and the other shows the percentage of details that were paid for that claim cycle. I also revised the cluster of denial reasons and am open to suggestions about whether the attached listing of 'EOB (Explanation of Benefit) Denial Groupings' needs to be reworked.

Lastly, I added two prototypes of new reports that I thought might be useful. Again, I am open to comments on these. Both provide data across a series of claim cycles. One of the new reports is specific to a provider and shows the denial reasons they have received. The other is grouped by broad classes of providers (e.g. hospital outpatient, hospital inpatient, mental health clinic. etc). I expect that the committee members will comment on these at the next meeting. In particular, I wonder whether it is useful or misleading to include the row for "duplicate claim" since these reflect claims that were paid once but submitted a second time and the second submission was denied as a duplicate. Providers might find it useful to know how often their billing department (or service) is submitting multiple claims for the same service but it artificially inflates the number of denials.