

HealthSystems



HealthSystems
OF MISSISSIPPI

A blue silhouette of the state of Mississippi is positioned behind the main title text.

**Community Mental
Health Services
Provider Manual**

Effective 05/01/09

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Of Mississippi

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I. Introduction

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform post-payment and quality review for Community Mental Health services rendered to Mississippi Medicaid beneficiaries.

We have been contracted with the Mississippi Division of Medicaid (DOM) providing utilization and quality of care review since 1997. Our review is performed for the following types of services.

- Inpatient Acute Hospitals.
- Free Standing Psychiatric Inpatient Hospitals.
- Psychiatric Residential Treatment Facilities.
- MYPAC – Mississippi Youth Programs Around the Clock.
- Hospital Outpatient Mental Health Services.
- Community Mental Health Post Payment Review.
- Outpatient Physical, Occupational and Speech Therapy.
- School Health Related Outpatient Physical, Occupational and Speech Therapy.
- Home Health.
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies.
- Private Duty Nursing.
- Medical Necessity Review for Organ Transplant.

The purpose of this manual is to assist providers in successfully navigating through HSM's post-payment review requirements and process.

II. Getting Started - Helpful Tips

Before responding to any request from HSM, providers must read and be familiar with DOM's policies and procedures located at <http://www.medicaid.ms.gov/manuals.aspx>.

Verify that the procedure code that you plan to submit information on requires review by HSM. Our Web site can be located at www.hsom.org.

Requests for medical records will be sent to Community Mental Health Centers following:

- Service rendered to the Medicaid beneficiary by a Community Mental Health provider.
- Community Mental Health provider submits claim for identified procedure codes.
- Quarterly random sample selection from all Community Mental Health provider claims data.

Requests for records contain only those procedure codes listed in Section IV of this manual, Community Mental Health Post-payment Procedure Codes.

HSM utilizes the Milliman Care Guidelines® when making review determinations. However, you do not need to purchase these guidelines. HSM also utilizes the MS Department of Mental Health Bureau of Mental Health Record Guide and the Division of Medicaid provider policy and procedures for community mental health services (section 15).

III. Information You Need to Know

Required forms and instructions are included in this manual and can be downloaded from the HSM Web site at www.hsom.org.

Community Mental Health post-payment review requests are accepted by fax or mail. A dedicated fax number is provided for submission of your records. Although we can accept mailed requests, fax submission provides a faster receipt of your records.

The table below list fax and phone numbers and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
Post-payment Review Request Submission	Used by providers to submit review request and additional information requested by HSM.	Hours: 24 hours, 7-days a week. Faxes received after 5:00 p.m. or over the weekend or holidays are considered received the next working day. FAX: 1- 877-272-8717 Mail: Attn: HSM – Post-payment Review 175 East Capitol Street Suite 250, Lock Box 13 Jackson, Ms 39201
Helpline	Used by providers for questions regarding the certification process and to request assistance.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Local: 601-360-4949 Toll Free: 1-866-740-2221
Hot Line	Used by beneficiaries and providers to report quality concerns and/or complaints.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Toll Free: 1-888-204-0221

IV. Community Mental Health Procedure Codes

Community Mental Health services beginning January 1, 2009 and coded to one or more of the following procedure codes are subject to post-payment review by HSM. A random sample will be selected quarterly from all Community Mental Health services billed to Medicaid.

Procedure Code	Service Name	Unit Measurement	Service Limitations	
			Daily	Yearly
T1017	Case Management (Adult)	Per 15 Minute Unit	96*	576*
T1017	Case Management (Child)	Per 15 Minute Unit		
H2019	Individual Therapeutic Support	Per 15 Minute Unit		
H2015	School Based Services	Per 15 Minute Unit		
H0039	Mental Illness Monitoring Services (MIMS)	Per 15 Minute Unit		
H2030	Psychosocial Rehabilitation (Adult)	Per 15 Minute Unit	20	None
H2030	Psychosocial Rehabilitation (Elderly)	Per 15 Minute Unit	20	None
H2012	Day Treatment (Child)	Per 1 Hour Unit	5	None
H2017	Day Support (Adult)	Per 15 Minute Unit	20	None
H0035	Acute Partial Hospitalization	Per Diem	1	100

* Represents combined service limits for procedure codes.

V. Post-payment Review Process

A. Requests for Records

Providers submit records for review directly to HSM through fax or mail.

The following table describes the types of requests received from HSM, timeframes for submission, and required documentation for each type of request. Required forms and instructions are included in the *Forms and Instructions* section of this manual.

Request Type	Description	Submission Timeframe	Required Documentation
Initial Record Request	Notifies Community Mental Health Center liaison that a Medicaid beneficiary has been randomly selected and records need to be submitted regarding identified procedure codes.	Within 30 calendar days of HSM request.	<ul style="list-style-type: none"> • HSM Inventory Tracking Sheet on top of the medical record. • The medical record face sheet. • Documentation to substantiate the medical necessity of each billed service for the dates of service listed on the HSM Inventory Tracking Sheet, such as the treatment plan, progress notes, medication records, case management notes, day treatment notes, etc. as applicable.
Initial Record Request (Second Request)	Notifies Community Mental Health Center liaison that initial request was not received in the specified timeframe and needs to be submitted for identified Medicaid beneficiary.	Within 5 calendar days of HSM request.	<ul style="list-style-type: none"> • HSM Inventory Tracking Sheet on top of the medical record. • The medical record face sheet. • Documentation to substantiate the medical necessity of each billed service for the dates of service listed on the HSM Inventory Tracking Sheet, such as the treatment plan, progress notes, medication records, case management notes, day treatment notes, etc. as applicable.
Preliminary Utilization Review Findings Report (PURF) <i>*if applicable</i>	(PURF) is sent to providers as written notification of issues or questions identified during initial record review which require additional response.	Within 15 calendar days of HSM request.	<ul style="list-style-type: none"> • Copy of PURF summary report for the identified beneficiary. • Additional information in response to each issue identified.

B. Processing of Review Request

HSM has a diverse group of professionals that assist at various stages of the review process such as our Intake staff, who handle administrative functions. Our clinical staff is composed of registered nurses and psychiatrists. These highly qualified professionals make review determinations for Community Mental Health services. In addition, HSM employs social workers and other specialized disciplines that may provide consultation to first and second level reviewers. The following table describes our staff’s functions.

Staff	Functions
Non-clinical Support Staff (Intake Staff)	<ul style="list-style-type: none"> • Screen request for completeness. • May request additional non-clinical information. • Support all review functions.
First level reviewers (Registered Nurses)	<ul style="list-style-type: none"> • Apply DOM policy. • Apply DOM approved medical necessity clinical guidelines. • Apply quality of care triggers and screens. • May request additional information. • Refer requests that cannot be approved to a physician.
Second level reviewers (Physicians)	<ul style="list-style-type: none"> • Make determinations: <ul style="list-style-type: none"> - Based on documentation that supports medical necessity and appropriateness of setting.* - Patient-centered and takes into consideration the unique factors associated with each patient care episode. - Sensitive to the local healthcare delivery system infrastructure. - Based on his or her clinical experience, judgment and generally accepted standards of healthcare. • May request additional information. <p>*The physician reviewer may request additional information and attempt to contact the Community Mental Health medical director, clinical director, or treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.</p>

There are two types of situations that may cause a post-payment review to be issued a Preliminary Utilization Review Findings (PURF) report requesting additional information. The following table describes each situation with its corresponding timeframes for the submission of the requested information. If the information is not submitted by the due date then HSM will proceed with the review.

If...	Then	Timeframe for submission
1. Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	Fifteen calendar days.
Clinical information is needed by the: 2. First level reviewer. 3. Second level reviewer.	Clinical information required to complete the review is requested.	Fifteen calendar days.

C. Notification of Review Outcome

HSM provides written notification of final review results to providers only when issues continue to be unresolved.

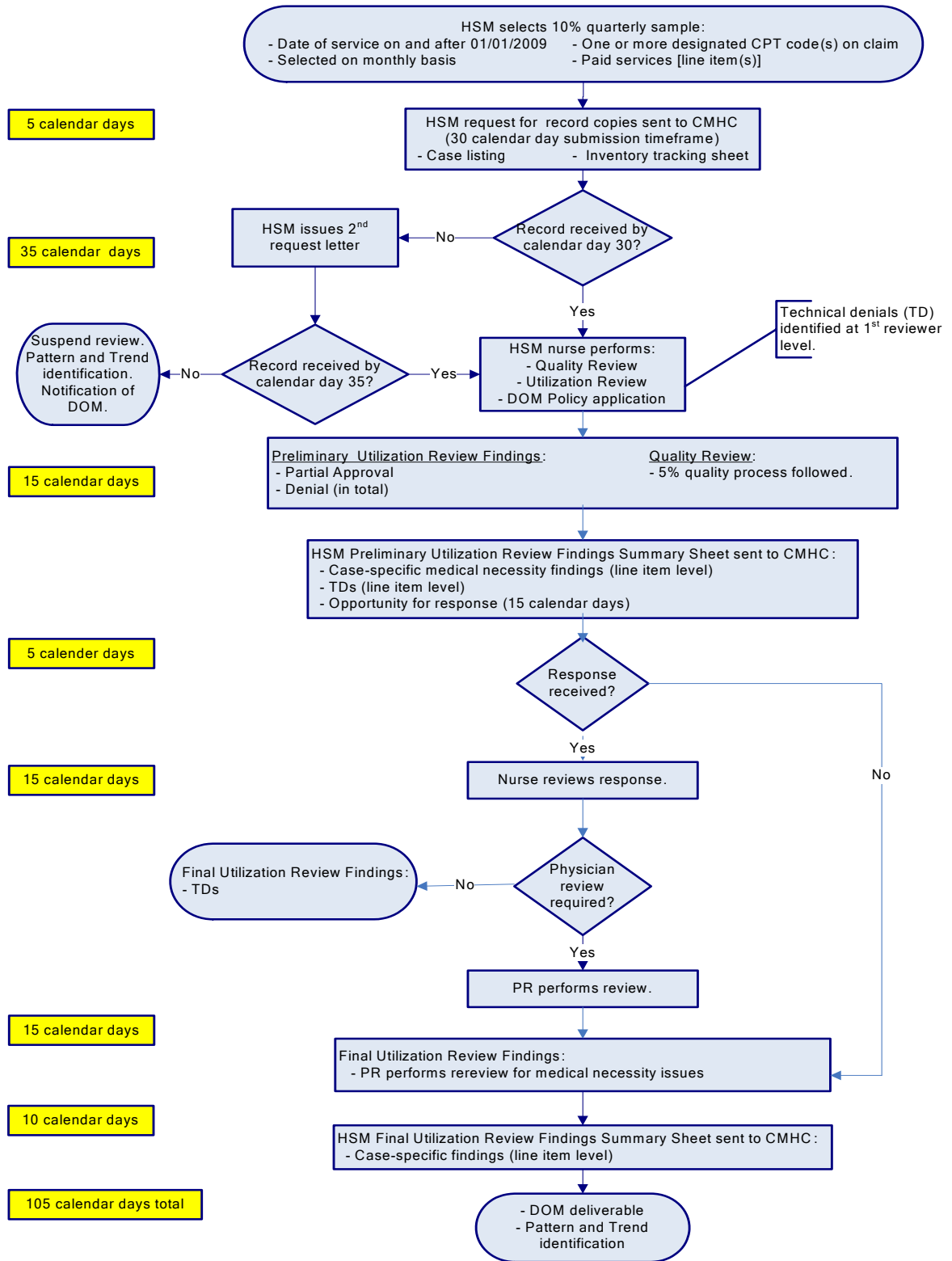
The following table contains the details of the notification process based on review outcome.

Review Outcome	Details
Final Utilization Review Report	<ul style="list-style-type: none">• If HSM determines that services are not medically necessary and appropriate for procedure identified in the request, a Final Utilization Review report will be issued to the provider stating the findings.

If HSM does not have any questions regarding the information received, then you are done!

D. HSM Review Process Flow Chart

COMMUNITY MENTAL HEALTH CENTER POST-PAYMENT REVIEW PROCESS



VI. Quality Review Process

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving community mental health services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by HSM. HSM identifies aberrant patterns and/or trends by provider.

Please see the ***Quality Review Process Manual*** for additional details.

VII. Utilization Analysis, Focused Studies, Outcome Reports, and Proposals for Improving Health Care Delivery System

Under contract with DOM, HSM will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.

We look forward to working with DOM and the Medicaid provider community on this endeavor.

VIII. Forms and Instructions

- Initial Post-payment Review Request - Community Mental Health Services.
- Post-payment Review Record Request (Second Request) – Community Mental Health Services.
- HSM Inventory Tracking Sheet- Community Mental Health Services.
- Preliminary Utilization Review Findings (PURF)- Community Mental Health Services.
- Final Utilization Review Findings- Community Mental Health Services.