



The Durham Center Clinical Review Plan

The Durham Center Utilization Management Team and Screening, Triage and Referral Team will engage in a clinical review process to help ensure consumers are receiving the most appropriate services at the proper level of intensity aimed at best meeting the goals of consumers served by the Durham provider network. The UM Department will provide both routine clinical reviews and clinical reviews triggered by certain noted issues. The process and procedures related to the clinical reviews are outlined below.

The clinical reviews will consist primarily of record reviews performed by UM or STR clinicians. For routine reviews, UM/STR clinicians will review three randomly-requested consumer records from the provider being reviewed. When a review is initiated as a result of a trigger event, in addition to the three randomly-requested records, the record of the consumer/consumers who triggered the review will also be examined. The UM/STR Department will conduct a total of eight clinical reviews per month. The number of random reviews will be determined by the number of reviews that result from a trigger issue.

A priority for the reviews will be for consumers who are identified on the monthly, State high-cost consumer report. Agencies providing services to either or both State-funded and Medicaid-covered consumers will be subject to clinical reviews. While the primary goal of the clinical review is to ensure appropriate care, other significant goals are to identify training needs that could improve care provided and to ensure appropriate use of public resources.

Events that may trigger a clinical review:

- Consumer complaint regarding a provider that has been forwarded by The Durham Center Compliance Director
- Identification of high-cost consumers as defined by the State. The State sends this report to the LME on a monthly basis. The top 1% of the high-cost consumers will be reviewed.
- Concerns about the person-centered plan.
- Pattern of consumer discharges from service that indicate a high level of consumer no-shows. Currently, IPRS discharge will be sent to the LME via Carelink. The UM manager assigned to the client will receive and review the discharge summary.
- Pattern of authorization requests that lack medical necessity for care.
- Referrals from ValueOptions, the company that performs utilization management of consumer care that is covered by Medicaid, for Cases of Concern.

Process

Each month the UM Director will select eight providers who will receive a clinical review. These providers will receive a letter from the LME requesting that the provider deliver copies of the person-centered plans, service notes and clinical assessment, on three consumers that have

been identified by the LM. The LME will identify the records for review. The provider will have seven days to deliver the requested documentation to the LME.

When the review is routine, i.e. not initiated as the result of a trigger event, consumers will be randomly selected based on Medicaid or IPRS paid claims data. When the records are delivered to the LME, a UM Support Team member will log in the records. A summary of the review will be completed within 14 days of the receipt of requested documentation and will be sent to the provider agency and the LME Compliance Director.

The UM Director will assign UM clinicians responsible for conducting the clinical review. The UM clinicians will use an LME-altered version of the NC Department of Health and Human Services Post-Payment Review Tool developed in 2007 to review each consumer record that is part of the clinical review. The form was initially developed by the State for the clinical review of consumers receiving Community Support.

The UM reviewers will also follow the guidelines that accompany the State review form. However, the guidelines will be applied to all services that are reviewed. The Durham Center will use the review form and guidelines to complete the clinical review of any clinical service provided to a consumer and to make clinical and administrative determinations.

The administrative response to the clinical review is different than the responses listed in the Post-Payment Review Guidelines. Findings on each consumer reviewed will be entered on an electronic version of the form that is available in Netsmart, The Durham Center's management information system. Based on this information gathered during the clinical review, a Summary of Findings will be prepared by the UM Director or designee. This report will be shared with the provider.

A clinical review may result in one of the following responses from the UM Department:

- No recommendations
- Change of service recommendations
- Training recommendations to the provider
- Referral to The Durham Center Corporate Compliance Director, who may choose to conduct a more comprehensive review or to initiate a referral to the NC DMA Accountability Section.