

Nebraska Division of Behavioral Health

MQIT

March 26, 2013 / 9:00-10:00 a.m. Central Time
DBH/Live Meeting & Conference Call

Meeting Notes

I. Attendance

Heather Wood

- Region I - Judie Moorehouse
- Region II – Angie Smith, Kathy Seacrest, Mary Wagner
- Region III - Ann Tvrdik
- Region IV –Ginger Marr, Tana Godel
- Region V – Linda Wittmuss
- Region VI – Joel Case, John Murphy, Stacey Brewer
- Magellan – Lisa Christensen
- DBH –Bob Bussard, Carol Coussons de Reyes, Cody R Meyer, Heather Wood, Kelly Dick, Ying Wang

II. Welcome

Heather Wood

- Heather welcomed attendees to the meeting. Attendance was taken.
- Overview of agenda. No additions were requested.
- The February 26, 2013 minutes were approved. No additions or questions were noted.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Send approved February minutes to group via email and post on web site: http://dhhs.ne.gov/behavioral_health/Pages/beh_mqit.aspx	Kelly Dick	Complete

III. Regional Questions/Discussion

Lisa Christensen

- ***Regions that have questions for Magellan should have these to Bob Bussard by the end of day Thursday, prior to the next scheduled MQIT meeting*** (Robert.bussard@nebraska.gov).
- Answers will be better addressed if Regions are able to submit their questions with examples or other details rather than generic questions.

- Region V Questions
 1. Is there an agreed upon definition for “origin of referral”?
 - For example, a client is referred for assessment and treatment by law enforcement. Provider A does the AOD assessment (referral source: law enforcement). Provider A refers the client to Provider B for treatment. Should Provider B indicate referral source as law enforcement or the assessment provider?
 - To make this information most useful is it best to capture how the client first entered the system, or to capture the progression from provider to provider? The intended purpose of this information will inform the final answer to the question and reflect in more consistent data.
 - There are inconsistencies in interpreting how this type of scenario should be addressed. Some agree Provider B should indicate their referral source is Provider A, and others suggest there is a potential benefit for listing law enforcement as Provider B’s referral source. Considerations:
 - What is the intent of asking the question of referral source? Is the purpose to capture each outside referral source?
 - If Provider B is looking for treatment information, is it more helpful to go back to

- Provider A who has the most recent client information, or to the original referrer of law enforcement (as in this scenario)?
- Episode of Care - recovery path from one level of treatment to another level of treatment - do we want the original referral source to follow the client throughout?
- Patti Ryan, at Magellan, is looking at this question, but she is out of town this week. Revisiting the question at the April meeting will allow her to provide input on the topic from Magellan's perspective.
 - This is a TEDs data element. The suggestion was made to take a point-in-time look at admissions to see how different assessments vs. others look in regard to referral sources.
 - Heather requested that regions share this question/scenario with their RQIT groups/providers. Bring summaries of discussion to MQIT next month.
 - The suggestion was made that a workgroup continue working on this topic. This will be discussed further in April.
2. Was there resolution to definition of "living situation"? Also, "destination at discharge" if client is discharging to another program within the same agency, etc.?
- Destination at discharge, though unclear, is related to treatment. The options are all intended to capture where the client is going within the treatment system. When this is understood, the selection of "other" for destination of discharge is suggested for the client who is leaving treatment. Perhaps "other" could be worded differently, the wording of "destination at discharge" could be made more indicative of the intent of the question, or the Provider Manual could include a more thorough explanation.
 - The comment was made that as a recovery based system of care, there should be a way to reflect it in "destination at discharge."
 - When the client is not moving to another level of care, the choice for "destination at discharge" will be "other", and the choice for "discharge status" will be "treatment completed."
 - It was recommended that a workgroup be formed to determine how to capture the desired information and determine the data elements needed.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Regions share question 1 with RQIT groups and bring results back to MQIT in April for further discussion on the topic (to include Patti Ryan).	Regions	April 23, 2013
Take a point-in-time look at admissions to see how different assessments vs. others look in regard to referral sources.	DBH Data Team	April 23, 2013
Continue sharing questions with DBH and Magellan to discuss at our MQIT meetings.	Regions	Ongoing

IV. Magellan Updates

Heather, Bob Bussard, Magellan

A. Report Discussion

The Average Handle Time Report and the Appeals (Clinical Review) Report will be available each month as handouts via Live Meeting. Discussion will be limited to one report each month, unless a specific request is made to discuss another report.

Reports Discussion: Appeals Report (Excerpts Attached)

Lisa Christensen reviewed the February 2013 report. The report shows the total authorizations (including auths and reauths), peer reviews and reconsideration reviews, with Medicaid and Non-Medicaid categories. The report is being reworked and changes include the following:

- The Auth Rate has been removed and will be replaced with a truer picture of the denial rate.
- Previously all reviews were separated into two (peer and reconsideration). Now if there is a peer review that then goes to reconsideration, this will be considered one review or authorization (a

continuation of the same review). The report will show the final outcome of each review/authorization. This will provide a more accurate picture of what Medicaid is paying for and will allow Magellan to respond to requests for the “auth denial rate”, which will now be calculated by the number of denials (numerator) over the number of requests (denominator).

- In the “All Review” sections of the report, the column, “total requests” will be added back in.
- A request was made to add footers to the report explaining calculations.
- Changes will be applied per discussion, and the Appeals Report will be reviewed again at the April meeting.

B. Reporting Updates

Bob Bussard

EPC & CPC Discharge: Some providers continue to have many discharges that were not removed at the time of Magellan’s administrative discharge. Regions, please send specific examples of these providers and discharges to Patti Ryan at Magellan (PORyan@MagellanHealth.com), and copy Heather Wood and Bob Bussard (heather.wood@nebraska.gov & robert.bussard@nebraska.gov).

CPT Code Follow Up

Heather Wood

- Magellan may have a fix and DBH will be meeting soon with Magellan to walk through solutions.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Forward specific example(s) - securely - of discharges that continue to appear on their reports to Patti Ryan, Bob Bussard, and Heather Wood (emails above).	Regions (mentioned: Regions 3 & 6)	ASAP
Continue/finalize reconstruction of Appeals Report share with group at April MQIT meeting	Lisa, Magellan	April 23, 2013

V. Other

Heather Wood

Provider Manual Feedback

Please continue to provide feedback as it is received.

VI. Meeting Close

Heather, Bob, Group

Call for April MQIT Agenda Items:

- Continue “referral source” and “destination at discharge” discussions based on feedback from regional conversations.
- Magellan Appeals Report
- Please forward items to Bob Bussard or Heather Wood by Thursday, April 18.

- Next meeting: April 23, 2013, 9:00 – 10:00 a.m. Central Time
- Adjourned at 10:00 a.m.

Notes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Notes are intended to provide only a general summary of the proceedings.

Magellan Health Services
NBHS Clinical Review Activity [Excerpt page 1 of 2]
February 2013

ALL REGIONS																		
All Reviews			Not Medicaid Eligible							Medicaid Eligible								
Total Auths	Auth Denial Rate	Rvw Denial Rate	Level of Care	Rvw	Rvw Auth	Rvw Deny	Recon	Recon Auth	Recon Deny	Rvw Denial Rate	Level of Care	Rvw	Rvw Auth	Rvw Deny	Recon	Recon Auth	Recon Deny	Rvw Denial Rate
11	0.0%		ACT								ACT - MRO							
18	0.0%		ACT-Alternative								ACT-Alternative - MRO							
280	2.5%	41.2%	Acute Inpatient	17	10	7				41.2%								
325	1.8%	66.7%	Community Support - MH	6	2	4				66.7%	Community Support - MRO	3	1	2				66.7%
75	2.7%	100.0%	Community Support - SA	2		2				100.0%	Community Support - ASA							
177	0.0%	0.0%	Day Rehabilitation	1	1					0.0%	Day Rehabilitation - MRO							
17	0.0%		Day Treatment - MH															
19	0.0%		Dual Disorder Residential								Dual Disorder Residential - ASA							
33	3.0%	100.0%	Halfway House - SA	1		1				100.0%	Halfway House - ASA							
			Intensive Outpatient - MH															
82	3.7%	75.0%	Intensive Outpatient - SA	4	1	3				75.0%	Intensive Outpatient - ASA							
10	0.0%		Intermediate Residential - SA								Intermediate Residential - ASA							
78	0.0%		Outpatient - SA								Outpatient - ASA							
23	0.0%	0.0%	Psychiatric Residential Rehab								Psychiatric Residential Rehab - MRO	1	1					0.0%
5	0.0%		Secure Residential															
122	0.8%	50.0%	Short Term Residential Tx - SA	2	1	1				50.0%	Short Term Residential Tx - ASA							
33	6.1%	66.7%	Sub-Acute Inpatient	3	1	2				66.7%								
18	0.0%	0.0%	Therapeutic Community - SA								Therapeutic Community - ASA	1	1					0.0%
36	0.0%	0.0%	Other LOC								Other LOC	1	1					0.0%
1362	1.6%	52.4%	Totals ►	36	16	20				55.6%	Totals ►	6	4	2				33.3%

Magellan Health Services
NBHS Clinical Review Activity [Excerpt page 2 of 2]
Fiscal Year to Date = July 1, 2012 - February 28, 2013

ALL REGIONS																		
All Reviews			Not Medicaid Eligible							Medicaid Eligible								
Total Auths	Auth Denial Rate	Rvw Denial Rate	Level of Care	Rvw	Rvw Auth	Rvw Deny	Recon	Recon Auth	Recon Deny	Rvw Denial Rate	Level of Care	Rvw	Rvw Auth	Rvw Deny	Recon	Recon Auth	Recon Deny	Rvw Denial Rate
74	1.4%	100.0%	ACT	1		1				100.0%	ACT - MRO							
104	0.0%		ACT-Alternative								ACT-Alternative - MRO							
1977	2.5%	53.8%	Acute Inpatient	93	42	51	2	1	1	53.8%								
3378	1.7%	68.3%	Community Support - MH	61	18	43	5		5	70.5%	Community Support - MRO	21	8	13	1		1	61.9%
612	0.5%	100.0%	Community Support - SA	3		3				100.0%	Community Support - ASA							
1230	0.7%	53.3%	Day Rehabilitation	13	6	7	2		2	53.8%	Day Rehabilitation - MRO	2	1	1	1		1	50.0%
100	0.0%		Day Treatment - MH															
192	0.0%		Dual Disorder Residential								Dual Disorder Residential - ASA							
273	0.7%	66.7%	Halfway House - SA	3	1	2				66.7%	Halfway House - ASA							
			Intensive Outpatient - MH															
692	1.7%	75.0%	Intensive Outpatient - SA	15	3	12				80.0%	Intensive Outpatient - ASA	1	1					0.0%
66	0.0%		Intermediate Residential - SA								Intermediate Residential - ASA							
967	0.0%		Outpatient - SA								Outpatient - ASA							
224	3.6%	53.3%	Psychiatric Residential Rehab	11	4	7	2		2	63.6%	Psychiatric Residential Rehab - MRO	4	3	1	1		1	25.0%
87	0.0%	0.0%	Secure Residential	2	2					0.0%								
935	0.3%	50.0%	Short Term Residential Tx - SA	6	3	3	1		1	50.0%	Short Term Residential Tx - ASA							
312	1.0%	27.3%	Sub-Acute Inpatient	11	8	3				27.3%								
162	0.0%	0.0%	Therapeutic Community - SA								Therapeutic Community - ASA	1	1					0.0%
295	0.0%	0.0%	Other LOC								Other LOC	1	1					0.0%
11680	1.3%	58.6%	Totals ►	219	87	132	12	1	11	59.8%	Totals ►	30	15	15	3		3	50.0%