BHRS POLICY: 19-04, Utilization Management Program – Interrater Reliability Testing
Attachment A: Interrater Reliability Testing Protocol

NOTE: "Authorization" means the same as "organizational determinations"

1) Authorizations Testing: A random sample of ten authorizations, selected by the ACCESS Call Center Psychologist, shall be chosen for each decision-making staff that authorize. A peer shall be recruited selected by the ACCESS Call Center Psychologist to review each authorization for the following:

    A. Diagnosis Appropriateness
        1. What is the diagnosis? Review the diagnosis criteria in the DSM 5
        2. Do the supporting documents (submitted assessment and treatment plan) provide enough evidence to accurately diagnose the disorder? Consult the diagnosis criteria in the DSM 5.
            a) The supporting documents must show evidence of all the required diagnostic criteria in order to show that the beneficiary was appropriately diagnosed.
            b) Authorization materials (Initial Contact Notes, Authorization Report, Milliman Care Guidelines) must include written documentation of diagnostic criteria.
    B. Treatment Appropriateness
        1. Is the treatment plan appropriate for the diagnosis?
            a) Does the treatment plan address the symptoms and impairments the client is experiencing?
    C. Appropriate Number of Sessions
        1. Do the assessment and treatment plan support the number of sessions identified by the Behavioral Health Utilization Models and Level of Care Statistics (22nd edition)?

2) Continuing Authorizations Testing:
    A. Diagnosis Appropriateness
        1. Does the assessment reflect a new diagnosis or the previous diagnosis?
            a) If it is a new diagnosis, does supporting documentation contain criteria that support the diagnosis?
            b) If this is the previous diagnosis, how are the symptoms the same? How are the symptoms different?

B. Treatment Appropriateness
    1. If the diagnosis is new, do the treatment interventions adequately support the treatment plan goals and objectives? Are the objectives measurable?
    2. If the diagnosis is the same as before, which treatment interventions have worked, which have not? What new strategies are being implemented to help the client?
    3. Is this treatment plan different than before? Does it contain updated goals and objectives? Are they measurable? Do the supporting documents indicate client progress?

C. Appropriate Number of Sessions
    1. Do the assessment and treatment plan support the number of sessions identified by the Behavioral Health Utilization Models and Level of Care Statistics?

3) <u>Retrospective Reviews Testing:</u>

A. Diagnosis Appropriateness
    1. What is the diagnosis? Review the diagnosis criteria in the DSM 5
    2. Is there sufficient documentation in the chart to provide enough evidence to accurately diagnose the disorder? Consult the diagnosis criteria in the DSM5.
        a) The chart must show evidence of all the required diagnostic criteria to be appropriately diagnosed.
        b) The chart must include written documentation of diagnostic criteria.

B. Treatment Appropriateness
    1. Does the chart include sufficient documentation to support medical necessity and appropriateness of the treatment provided? Was the treatment appropriate for the diagnosis?

C. Appropriate Number of Sessions
    1. Does the chart support the number of days or units of service identified by the Behavioral Health Utilization Models and Level of Care Statistics.
    2. Does review of the medical record, including treatment plan substantiate authorization of service?
    3. Were all treatment services provided authorized?

D. Additional Information to Review
    1. Is the retrospective review period 10 days or fewer?

2. Does the documentation support the organizational determination made to allow or disallow a service?
3. Did the provider correctly bill the proper number of days or units of service? Did the provider identify days or units of service that should be disallowed? How was the determination made as to which days would be disallowed and what was the criteria used in making the determination?

4) Denials Testing:

1. Does the record reflect that the client and the provider were notified in writing of the denial (including partial denial) and does the denial notice contain the following information?

    a) the specific reasons for the denial in easy to understand language;

    b) a reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based; and

    c) a statement that clients can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request.

2. Does the record reflect that the provider was afforded the opportunity to discuss denials with the Medical Director, Deputy Medical Director, or other appropriate reviewer?

3. Was the denial recorded in the denial log?

4. Was the denial provided using the correct notification template that states the reason for the denial and references the source of the information used in the determination of the denial?

5. Was there proper notice of appeal rights included in the denial letter?

6. Was the denial letter sent timely and was this properly recorded?