

"Why Quality Review?"

As part of College Health IPA's (CHIPA) continuing efforts to improve the quality and effectiveness of our services, and to meet the expectations of the new Federal Parity law, CHIPA has modified its former Outpatient Utilization Management process. Our current management approach is a "Quality Review Program", effective as of December 1, 2010.

The philosophy of the Quality Review Program is to 1) streamline access and transitions to all levels of care 2) assess barriers and unresolved treatment needs and 3) expand the resources available to enhance the care received by members.

"No authorization required?"

The most significant change in the process has been the introduction of Registrations and cessation of the preauthorization requirement. **Providers are no longer required to submit Provider Assessment / Authorization Request (PAAR) forms for ongoing authorization and claims payment.** The only exception applies to psychological testing which will continue to have the same pre-authorization requirement.

Registrations are different from authorization because they are not intended to fulfill a requirement, but instead serve to facilitate access to care, confirm eligibility and accelerate claims processing. Routine outpatient office based treatment can be registered upon request by either the member or provider or upon receipt of a claim. While Registration is not required for claims payment, patients and providers are strongly encouraged to register services with CHIPA by calling 800-779-3825.

"What Triggers Quality Review?"

The new "Quality Review Program" is designed to identify services that fall outside of typical practice patterns and/or clinical standards of care. These services are identified through screening for pre-set triggers that catch practice anomalies and alert our Case Management team to potential quality of care issues. Following are examples of quality review triggers.

- Urgent referral
- Multiple hospital readmissions
- Dual diagnosis
- Co-morbid medical conditions
- SMI diagnosis, but no MD registration
- Minor in treatment without family therapy
- NOS or other term specific diagnosis for 6 months or more
- Multiple DOS per week
- Services exceeding one year Registration
- Duplication of services (two providers billing for services)
- Non-standard CPT code
- Quality of care complaint

A quality review trigger results in a call to the provider from a CHIPA case manager. Providers can expect to be contacted on occasion by a licensed case manager or our Medical Director to complete a quality review. In some cases, providers may be asked to submit medical records for review and/or participate in an annual record audit.

“What information might be asked for?”

The objective of a quality review is to establish that each member is receiving standard practice of care. The clinical information needs to sufficiently establish that treatment is necessary and consistent with applicable terms of coverage. Below are some examples of requested clinical information.

- Initial assessment / psychosocial history
- Current risk assessment / Mental Status Exam
- History of prior treatment / history of psychological testing
- Comprehensive treatment plan
- Assessment of member compliance with treatment plan
- Established plan for coordination of care
- Assessment of barriers to progress

If requested information is not received a denial may result. The denial may be either an administrative denial for lack of information or a clinical denial if the quality of care issue is not supported by the available clinical information. Once a denial is issued, any further consideration for coverage of service would require an appeal following the guidelines of the primary insurance plan.

To avoid time consuming and frustrating Denials and/or appeals CHIPA asks providers to partner with us in the quality review process.