FY 2017/18 CLAIMS VERIFICATION / CLINICAL RECORD REVIEW

	Follow-Up Primary ACT, Homebased, Wraparound, Outpatient Therapy, Targeted Case Management, Supports Coordination, Specialized Residential
SECTION 1 - PRIMARY ASSESSMENT	
1.4 A subsequent assessment is completed within 365 days and precedes the IPOS.	**X**
An Assessment is to be completed prior to the IPOS which is required to be updated within 365 days (annually).	
2 - Assessment updated on time, before 13 months	
1 - Assessment update completed late but no later than 14 months	
0 - Assessment updated more than 14 months late, or not at all	
Source Requirement	
MDHHS PIHP Contract Attachment P.4.4.1.1 Person-Centered Planning Policy & Practice Guideline	
SWMBH Operating Policy 12.11.III	
SECTION 3 – INDIVIDUAL PLAN OF SERVICE (IPOS)	
3.1 There is a current, complete and signed IPOS in the record.	**X**
2 - *Primary* : Full current plan is present and signed by the consumer or legal guardian if guardianship is in place; *Ancillary* : present or has been reviewed within 30 days of the date it is uploaded in Streamline	
1 - n/a	
0 - Current IPOS not completed within 365 days and no documentation providing rationale for delinquent plan development	
Source Requirement	
MDHHS PIHP Contract Attachment P.4.4.1.1 Person-Centered Planning Policy & Practice Guideline	
Medicaid Provider Manual (Mental Health and Developmental Disabilities Services (2.1) & Substance Abuse Services (2.2), Medical Necessity Criteria 2.5.B	
CARF (2017) 2.G.4	
3.3 A preliminary plan is to be completed within 7 days of the commencement of services (based on the first ongoing appointment).	**X**
Preliminary planning can be met through a stand alone preliminary plan document, through information documented in the primary assessment interpretive summary if it includes information on needs, recommended services and interventions, goals, etc. Also can be met through the completion of the pre-plan if done within 7 days of the first contact.	
2 - Preliminary planning is documented within 7 days of the initiation of ongoing services	
1 - N/A	
0 - No documentation of preliminary planning within 7 days of the initiation of ongoing services	
Source Requirement	
KCMHSAS Policy 33.01 Person Family Centered Planning Process	
Michigan Mental Health Code 330.1712 (1)	

		Follow-Up Primary
3.6	***The claimed service was identified in the Individual Plan of Service and/or through Addendum.***	***X***
	2 - Clear evidence of the claimed service is present in the plan with the correct amount, scope, duration, intensity, frequency and rendering provider	
	1 - One element is missing	
	0 - More than one element is missing	
Source Requirement		
Medicaid Provider Manual 2.1		
3.8	**The IPOS includes 1) services (scope) required to achieve the objective; 2) person(s) responsible for implementation; 3) amount (how much); 4) frequency (how often); and 5) duration (how long) for each service.** *For example, a plan of Service might identify that individual therapy would be provided, that (name) will be the therapist providing the Service, and that therapy will take place for one hour, one time per week, For six weeks.* *Services are to be called formal name based on the Medicaid Provider Manual and are to be identified separately in the IPOS (i.e. Psychiatric Evaluation and Medication Review).* *Score only if Psych Services is the Primary program and the IPOS is completed by the Psych Service Care Coordinator.*	**X**
	2 - All required elements are present and correct	
	1 - At least one of the required elements is missing and/or incorrect	
	0 - Two or more of the required elements are missing and/or incorrect	
Source Requirement		
KCMHSAS policy 33.01 (Person/Family-Centered Planning Process)		
MDHHS PIHP Contract Attachment P.4.4.1.1 Person-Centered Planning Policy & Practice Guideline		
Medicaid Provider Manual (Mental Health/Substance Abuse Section 2.1		
Balanced Budget Act of 1997, Section 438.10 (f)(6)(v)		
CARF (2017) 2.C.2		
3.11	***Cultural needs and preferences are assessed through the primary assessment and identified in the IPOS when needs are identified (Consultative).***	***X***
	2 - All identified cultural needs are addressed by the plan and/or through needed referrals	
	1 - Needs are identified but are general or vague	
	0 - Needs not sufficiently addressed by the plan or referrals OR there is no plan in place.	
Source Requirement		
KCMHSAS Cultural and Linguistic Plan		
3.18	**A signed Consent for Treatment, that includes the right to withdraw the consent, is included in record and updated annually.**	**X**
	2 - A current signed Consent for Treatment is found in the record	
	1 - N/A	
	0 - A current signed Consent for Treatment is not found in the record	
Source Requirement		
KCMHSAS Policy 32.01 (Intake and Clinical Assessment)		
Michigan Mental Health Code Rule 330.7003		

	Follow-Up Primary
3.23 A subsequent plan is completed within 365 days of a prior plan or in response to a request from the person served.	**X**

2 - Plans are completed entirely within the listed requirements or there is documentation in the record providing rationale why it will be beyond 365 days (unforeseen emergency, incarceration) with plan for timeline of completion)
1 - *Primary* : no option for a score of 1; *Ancillary* : current plan not present, but there is documentation in the record that the Ancillary provider repeatedly attempted to obtain the full IPOS from the primary provider (including contacting the contract manager and/or CMHSP when needed)
0 - *Primary* : Plans are not completed entirely within the listed requirements or there is no documentation in the record providing rationale why it will be beyond 365 days (unforeseen emergency, incarceration) with plan for timeline of completion); *Ancillary* : current plan not present, and there is no documentation in the record that the Ancillary provider repeatedly attempted to obtain the full IPOS from the primary provider (including contacting the contract manager and/or CMHSP when needed)

Source Requirement

KCMHSAS Policy 33.01 (Person/Family-Centered Planning Process)

MDHHS PIHP Contract Attachment P.4.4.1.1 Person-Centered Planning Policy & Practice Guideline

Medicaid Provider Manual 2.1

SECTION 6 – DOCUMENTATION TO SUPPORT SERVICE PROVIDED

	Follow-Up Primary
6.1 Progress notes show that the frequency and amount of all identified and authorized services are implemented as indicated in the IPOS.	**X**

NOTE: *check Smartcare to ensure that all services are provided and billed at the frequency described in the IPOS*

2 - Documentation demonstrates that the frequency and amount/duration of contacts is consistent with the IPOS. Credit is also given when there is documentation in the record providing short term justification for a change in the service provision (individual is on vacation, there is a planned break in programming, medical issues/concern, etc.). If the change in the amount and frequency of the service extends for a longer period of time, an addendum is to be completed to change the Individual Plan of Service

1 - There is evidence in which services are not consistently provided in accordance with the IPOS, there is no rationale for gaps in service, but overall the services are delivered in accordance with the IPOS
0 - Services are not provided in accordance with the IPOS for an extended period of time, there is no documentation of reason of follow-up with the person served.

Source Requirement

42 CFR 440.230

MDHHS Protocol C.2.4

Medicaid Provider Manual 2.1

	Follow-Up Primary
6.2 Documentation in the record supports the date of service submitted on the claim.	**X**

2 - Clear evidence of date the service was provided

1 - Incorrect date, but it is evident that the service was provided in documentation available in record (i.e., typo error [date off by +/1 day], duplicate dates for the same day of service)
Recommendation: date of service is expected to be corrected in the system to match actual date of service; plan of action: needs to be corrected w/in 2 weeks of receipt of aggregate report, otherwise there would be recoupment of funds; comments: check against service billed to ensure other date was not billed; double check to make sure this is not a 15min service, as they can be seen 2x a day (although in this case there should be 2 progress notes in record)
0 - Missing documentation

Source Requirement

MDHHS Provider Manual Section 15.7 Clinical Records

MDHHS Provider Manual Section 15.1 Record Retention

SWMBH Operating Policy 12.11.III

	Follow-Up Primary
6.4 Documentation in the record supports the number of units submitted on the claim with start and stop times as required.	**X**
2 - Documentation in the record clearly supports the number of units of service claimed	
1 - Incorrect number of units claimed (under or over)	
0 - No start and/or stop time; no evidence or lack of sufficient evidence in the record to support the number of unit(s) of service claimed was/were delivered on this date	
Source Requirement	
Medicaid Provider Manual 15.7 Clinical Records	
MDHHS PIHP Reporting Requirements p 19 of 67	
CARF (2017) 2.C.7	
SWMBH Operating Policy 12.11.III	
6.7 The place of service reported on the claim is supported by documentation in the record.	**X**
2 - Used accurate POS code OR code utilized was partially applicable by using code "99" unless a specific code must be utilized as directed by EDIT	
1 - Place of Service code is partially applicable but incorrect (i.e. used code 12 for service that started at home and some community)	
0 - Used code that does not apply to actual POS (i.e., used code "12" for services that happened in the community, instead of "99")	
Source Requirement	
SWMBH Operating Policy 12.11.III	
EDIT documents 2016	
6.8 The service documentation was legibly signed by the appropriate credentialed provider(s) and dated as appropriate. If initials are used, there is a current and legible signature log in place. If signature is illegible the name is legibly printed beneath.	**X**
2 - Clear evidence that the documentation of the claimed service was legibly signed by an appropriately credentialed provider of service and dated. If initials are used by staff who do not have credentials (Specialized Residential, CLS, Respite), there must be a ledger in the record to show full names and initials of staff. Comments: support notes are both signed and dated, daily support notes/logs indicate DOS and have initials of all staff that provided the service for all available shifts (signatures do not have to be dated individually) **SPECIALIZED RESIDENTIAL SETTINGS ONLY**	
PSR/Clubhouse: Documentation of members' progress in the Clubhouse modality differs from documentation requirements in individual treatment modalities and is demonstrated in the following process. -Recovery progress can be documented in a variety of ways and, at a minimum, should be documented on at least a monthly basis. -The documentation process, regardless of the established frequency or process, should be streamlined to minimally disrupt the work-ordered day. -Progress note processing should be integrated into unit work. -Members have the opportunity to write his or her own progress notes. -Generally, all notes should be signed by both members and staff.	
1 - Documentation is initialed with no signature log OR signature is illegible	
0 - No evidence in the record that the documentation of the claimed service was signed by an appropriately credentialed provider of service or dated	
Source Requirement	
KCMHSAS Procedure 36.01_01 (Record Access)	
Medicaid Provider Manual	
CARF (2017) 2.C.7	
SWMBH Operating Policy 12.11.III	

	Follow-Up Primary
6.9 The service documentation was fully completed, signed and made available in the record within 3 days from date of service or 7 days post receiving dictation. (this includes valid signature by rendering clinician/staff). 2 - Fully completed, signed and made available in the record in a timely manner Comments: support notes are both signed and dated, daily support notes/logs indicate DOS and have initials of all staff that provided the service for all available shifts (signatures do not have to be dated individually) **SPECIALIZED RESIDENTIAL SETTINGS ONLY** 1 - Documentation is initialed with no signature log OR signature is illegible 0 - No evidence in the record that the documentation of the claimed service was signed by an appropriately credentialed provider of service or dated	**X**
Source Requirement *KCMHSAS Procedure 36.01_01 (Record Access)* *SWMBH Operating Policy 12.11.III*	

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CLAIMS VERIFICATION / CLINICAL RECORD FOLLOW-UP REVIEW

SECTION 1 - PRIMARY ASSESSMENT		Possible	Actual
1.4 A subsequent assessment is completed within 365 days and precedes the IPOS.			
	N/A	0	0

SECTION 3 – INDIVIDUAL PLAN OF SERVICE (IPOS)		Possible	Actual
3.1 There is a current, complete and signed IPOS in the record.			
3.3 A preliminary plan is to be completed within 7 days of the commencement of services (based on the first ongoing appointment).			
3.6 The claimed service was identified in the Individual Plan of Service and/or through Addendum.			
3.8 The IPOS includes 1) services (scope) required to achieve the objective; 2) person(s) responsible for implementation; 3) amount (how much); 4) frequency (how often); and 5) duration (how long) for each service.			
3.11 Cultural needs and preferences are assessed through the primary assessment and identified in the IPOS when needs are identified (Consultative).			
3.18 A signed Consent for Treatment, that includes the right to withdraw the consent, is included in record and updated annually.			
3.23 A subsequent plan is completed within 365 days of a prior plan or in response to a request from the person served.			
	N/A	0	0

SECTION 6 – DOCUMENTATION TO SUPPORT SERVICE PROVIDED		Possible	Actual
6.1 Progress notes show that the frequency and amount of all identified and authorized services are implemented as indicated in the IPOS.			
6.2 Documentation in the record supports the date of service submitted on the claim.			
6.4 Documentation in the record supports the number of units submitted on the claim with start and stop times as required.			
6.7 The place of service reported on the claim is supported by documentation in the record.			
6.8 The service documentation was legibly signed by the appropriate credentialed provider(s) and dated as appropriate. If initials are used, there is a current and legible signature log in place. If signature is illegible the name is legibly printed beneath.			
6.9 The service documentation was fully completed, signed and made available in the record within 3 days from date of service or 7 days post receiving dictation. (this includes valid signature by rendering clinician/staff).			
	N/A	0	0

Total Recoupment:

Medicaid	$0.00
General Fund	$0.00
SAMHSA	$0.00

OVERALL COMPLIANCE	Possible	Actual	%
SECTION 1 - PRIMARY ASSESSMENT	0	0	N/A
SECTION 3 – INDIVIDUAL PLAN OF SERVICE (IPOS)	0	0	N/A
SECTION 6 – DOCUMENTATION TO SUPPORT SERVICE PROVIDED	0	0	N/A
OVERALL SCORE	0	0	N/A

CONSULTATIVE	Possible	Actual	%
SECTION 3 – INDIVIDUAL PLAN OF SERVICE (IPOS)	0	0	N/A

0 ***cases reviewed***

0 ***requests for a Master Level, Licensed Clinician to conduct an additional review to determine if the individual is receiving the appropriate level of care/services.***