FY 2017/18 CLAIMS VERIFICATION / CLINICAL RECORD REVIEW

Follow-Up Ancillary
Community Living Supports, Skill Building Assistance, Supported / Integrated Employment Services, Respite Care Services, Peer-Delivered or Operated Support Services

SECTION 1 - PRIMARY ASSESSMENT

1.5 A current assessment from the primary provider is found in the record. **X**

2 - A current assessment from the primary provider is found in the record.

1 - Assessment is present in the record but more than one year old (not to exceed 14 months). If not found, documentation is present noting repeated attempts by the provider to obtain copies from the primary provider/clinician

0 - No primary assessment is present and no documentation is present to demonstrate repeated attempts to obtain from the primary provider

Source Requirement

CARF (2017) 2.G.4

CARF (2017) 2.G.4

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

3.6 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

	Follow-Up Ancillary
3.31 There is evidence that staff are trained when a new IPOS is developed or when there is a change to the IPOS as it relates to the specific service/provider. *For Aide level staff e.g. CLS, Respite, PC, Family Training, Skill Building, etc.), training includes documentation of:* *-Who was trained* *-Who the trainer was* *-When the staff was trained* 2 - Evidence of training for all staff for the IPOS and each update 1 - Evidence of training for the initial and annual IPOS but not addendums 0 - No evidence of staff training on the IPOS ***Source Requirement*** *MDHHS/PIHP Contract*	X
SECTION 6 – DOCUMENTATION TO SUPPORT SERVICE PROVIDED	
6.1 Progress notes show that the frequency and amount of all identified and authorized services are implemented as indicated in the IPOS. ***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*	X
6.2 Documentation in the record supports the date of service submitted on the claim. 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*	X

	Follow-Up Ancillary
6.4 Documentation in the record supports the number of units submitted on the claim with start and stop times as required. 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*	**X**
6.7 The place of service reported on the claim is supported by documentation in the record. 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*	**X**
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. 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*	**X**

		Follow-Up Ancillary
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 ***Source Requirement*** *KCMHSAS Procedure 36.01_01 (Record Access)* *SWMBH Operating Policy 12.11.III*	X
6.10	**There is evidence of the provider implementing auxiliary plans, when applicable, consistently as directed (PT, OT, Care Plan Protocols, Special Diet, etc.).** 2 - Consistent documentation is present and clearly demonstrates that supports / services are provided in accordance with the Individual Plan of Service and the Assessment / Evaluation / Plan 1 - Documentation does not clearly demonstrate implementation as written in the IPOS or is done inconsistently 0 - No demonstration of services/supports being provided as written ***Source Requirement*** *KCMHSAS policy 33.01 (Person/Family-Centered Planning Process)* *KCMHSAS policy 40.02 (Coordination with Primary Care Physician)* *CARF (2017) 2.C.7* *AFC Licensing R 400.14313* *AFC Licensing R 400.14316* *MDHHS PIHP Contract Attachment P.4.4.1.1 Person-Centered Planning Policy & Practice Guideline*	X

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

CLAIMS VERIFICATION / CLINICAL RECORD FOLLOW-UP REVIEW

SECTION 1 - PRIMARY ASSESSMENT		*Possible*	*Actual*
1.5	A current assessment from the primary provider is found in the record.		
		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.		
3.6	*The claimed service was identified in the Individual Plan of Service and/or through Addendum.*		
3.31	There is evidence that staff are trained when a new IPOS is developed or when there is a change to the IPOS as it relates to the specific service/provider.		
		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).		
6.10	There is evidence of the provider implementing auxiliary plans, when applicable, consistently as directed (PT, OT, Care Plan Protocols, Special Diet, etc.).		
		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*

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.***