FY 2018/19 CLAIMS VERIFICATION / CLINICAL RECORD REVIEW
SCORING DESCRIPTORS

		Ancillary: ABA, Community Living Supports, Skill Building Assistance, Supported / Integrated Employment Services, Respite Care Services, Peer-Delivered or Operated Support Services
SECTION 1 - PRIMARY ASSESSMENT		
1.4	**A current assessment from the primary provider is found in the record.** 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*	**X**
SECTION 3 – INDIVIDUAL PLAN OF SERVICE (IPOS)		
3.1	**There is a current, complete IPOS, signed by all necessary parties (consumer / guardian and primary clinician) in the record.** 2 - Primary: Full current plan is present and signed by the primary clinician and consumer /legal guardian if guardianship is in place; Ancillary: present or has been reviewed within 30 days of the effective date of the current IPOS 1 – Primary: no option; Ancillary: present or has been reviewed after 30 days of the effective date of the current IPOS in SmartCare or 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; current IPOS not completed and no documentation providing rationale for delinquent plan development. Ancillary: current plan not present nor was it reviewed in SmartCare, 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** *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*	**X**
3.23	**Periodic goal reviews from primary provider are found in record or there is evidence of access/review of this information in the Electronic Health Record (EHR) at the frequency indicated in the plan, not less than once/treatment year.** 2 - Periodic review is present in the record or has been reviewed by the provider in the EHR (if single provider) at the frequency as stated 1 - Periodic review is present in the record but not at the frequency identified in the plan or reviewed in the EHR but not at the frequency required. Reviewer will compare to date periodic review is made available. 0 - No periodic review present **Source Requirement** *KCMHSAS policy 33.01 (Person/Family-Centered Planning Process)* *Medicaid Provider Manual (Mental Health/Substance Abuse Section 2.1)*	**X**
3.25	**When a provider is implementing interventions from specific care protocols (seizure, BM, special diet, OT/PT, BTRC approved Behavior Treatment Plan, etc.) there is a current assessment/evaluation and service plan in the record.** 2 - Current specific assessment/evaluation and service plan that describes care protocols are in the record and coincides with IPOS	**X**

FY 2018/19 CLAIMS VERIFICATION / CLINICAL RECORD REVIEW
SCORING DESCRIPTORS

		Ancillary
	1 - Some related documentation regarding care protocols are in the record 0 - No documentation/direction regarding care protocols are in the record **Source Requirement** *Medicaid Provider Manual (Mental Health/Substance Abuse Section 2.1)*	
3.26	**A copy of the physician's referral and prescription for OT is found in the record when the service is identified in the Plan as provided through Specialty Mental Health services. A copy of the prescription signed by the physician and dated within 30 days prior to the initiation of the request for continued OT services. A prescription must include the following:** **- Beneficiary's name;** **- Prescribing practitioner's name, address and telephone number;** **- Prescribing practitioner's signature (a stamped signature is not acceptable);** **- The date the prescription was written;** **- The specific service or item being prescribed;** **- The expected start date of the order (if different from the prescription date); and** **- The amount and length of time that the service or item is needed.** **FOR OUTPATIENT PROVIDERS ONLY** *A verbal order from a physician or other licensed practitioner of the healing arts within their scope of practice may be used to initiate occupational therapy (OT), physical therapy (PT), or Speech, Hearing and Language services or to dispense medically necessary equipment or supplies when a delay would be medically contraindicated. The written prescription must be obtained within 14 days of the verbal order. The qualified therapist (OT, PT or Speech) responsible for furnishing or supervising the ordered service, or supports coordinator or case manager must receive and document the date of the verbal order in the individual plan of service. Upon receipt of the signed prescription, it shall be verified with the verbal order and entered into the individual plan of service.* 2 - Prescription from physician is obtained prior to services and meet all stated elements 1 - Prescription from physician is obtained and in the record but does not include all required elements 0 - Prescription present **Source Requirement** *Medicaid Provider Manual Section 1.7 and 7.1*	**X**
3.29	**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 5 – COORDINATION OF CARE		
5.1	**There is documented evidence of ongoing contact between the primary clinician and the ancillary provider.** *NOTE: recommend (not required) that this be a separate Document/log of all contacts For each consumer and kept in consumer record.* *Score based on messaging in Smartcare, any psych consults that are sent in, CM attendance at psych appointment, primary provider reviewing med reviews in Smartcare through the "Santa Claus" report.* 2 - Ongoing documentation of coordination between the primary and ancillary provider is present in the record or demonstrated through supplemental documentation. A consistent and clear mechanism is used to demonstrate coordination	**X**

FY 2018/19 CLAIMS VERIFICATION / CLINICAL RECORD REVIEW
SCORING DESCRIPTORS

	Ancillary
1 - Inconsistent evidence of coordination is present, including only form of communication / coordination being receipt of required documentation (Assessment, IPOS, etc.) being in the record, collaborative contacts between the ancillary and primary provider do not occur 0 - No documentation of coordination is evident in the record **Source Requirement** *KCMHSAS policy 31.07 (Recovery-Based Services)* *CARF (2017) 2.A.7.a* *CARF (2017) 2.A.7.b* *Medicaid Provider Manual 13.3*	
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**
6.3 Progress notes reflect back to specific goals/objectives implemented in the IPOS. *Progress notes should refer to goals/objectives and discuss Progress, thus demonstrating the plan of Service is indeed being carried out.* *Progress notes also Include documentation of the Service (i.e., med Review, Psych eval, injections, case management contact by the Psych Services Care Coordinator, etc.).* 2 - Focus on goals/objectives and progress toward goals/objectives are documented on all or nearly all progress notes 1 - Focus on goals/objectives and progress toward goals/objectives are documented inconsistently or are overly general 0 - Little or no documentation of goal/objective status in the progress notes	**X**

FY 2018/19 CLAIMS VERIFICATION / CLINICAL RECORD REVIEW
SCORING DESCRIPTORS

	Ancillary
Source Requirement *MDHHS PIHP Contract Person-Centered Planning Guidelines* *MDHHS Protocol C.2.4* *SWMBH Operating Policy 12.11.III* *CARF (2017) 2.C.7*	
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
6.5 Specific interventions/activities used by staff are recorded in each progress note. 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** *MDHHS PIHP Contract Attachment P.4.4.1.1 Person-Centered Planning Policy & Practice Guideline* *SWMBH Operating Policy 12.11.III* *CARF (2017) 2.C.4* *CARF (2017) 2.C.7*	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	X

FY 2018/19 CLAIMS VERIFICATION / CLINICAL RECORD REVIEW
SCORING DESCRIPTORS

		Ancillary
	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*	
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**
SECTION 8 – MEDICAL (MEDICATION MANAGEMENT)		
8.2	**Medication listed is current and accurate. Medication log matches information in medication prescriptions (could be electronic print-off of prescription [i.e., Infoscriber]) for 1) name of medication; 2) dosage and frequency; and 3) consumer name kept in individual record). (Applies only to Programs/Services who administer medications to individuals served.)**	**X**

FY 2018/19 CLAIMS VERIFICATION / CLINICAL RECORD REVIEW
SCORING DESCRIPTORS

		Ancillary
	2 - Medication lists are current, accurate, and all elements of documentation (listed above) are present 1 - Most medications listed are accurate for all elements but at least one error or omission is found 0 - Medication logs are generally not current and/or accurate, or are not found **Source Requirement** *KCMHSAS policy 44.02 (Pharmacotherapy)* *AFC Licensing R 400.14312* *CARF (2017) 2.E.4* *Provider Contractual Agreement Section a*	
8.3	**Medication administration is properly documented (staff initials for every administration for the period reviewed, proper documentation of problems/variation, signatures to correspond to initials, etc.). (Applies only to Programs/Services who administer medications to individuals served in licensed settings [i.e., Specialized Residential, Facility-Based Respite].)** 2 - Medication administration is properly documented and demonstrates that all medications are being administered in accordance with prescriptions. Including timely documentation of when a medication is added/changed/ discontinued 1 - Medication administration is not documented appropriately at all times and/or medication errors occurred without proper documentation and follow-up (I&A report, notifying primary clinician and prescriber). Lack of documentation to support when a medication was added/changed/discontinued 0 - Ongoing deficiencies noted in regards to medication administration documentation and/or administering medications as prescribed **Source Requirement** *KCMHSAS policy 44.02 (Pharmacotherapy)* *AFC Licensing R 400.14316* *CARF (2017) 2.E.4* *Provider Contractual Agreement Section a*	**X**