1617_QMR Scoring Descriptors_CVCRR_FINAL_Ancillary

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.

- **2** Full current assessment is present in the record or has been reviewed by the provider in EHR (if single provider)
- **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 (2012) 2.G.4
- CARF (2012) 2.G.5

SECTION 3 – INDIVIDUAL PLAN OF SERVICE (IPOS)

3.1 There is a current and complete IPOS in the record.

Services are not to be paid without an active/current IPOS per Medicaid Provider Manual guidelines

- **2** Primary: Full current plan is present
  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
  Ancillary: There is no documentation of attempts to obtain the IPOS from the primary provider. There is a current plan in the electronic system but there is no evidence that the Ancillary provider has accessed or reviewed the Plan electronically

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)
- CARF (2012) 2.G.4

3.5 The claimed service was identified in the Individual Plan of Service and/or through Addendum.

- ***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:

- MDHHS Protocol C.2.4
- MDHHS Protocol B.13 (Additional B3 Services)

3.25 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:

- Medicaid Provider Manual (Mental Health/Substance Abuse Section 2.1)
- KCMHSAS Policy (33.01 Person/Family-Centered Planning Process)

3.27 When a provider is implementing interventions from specific care protocols (seizure, BM, special diet, OT/PT, 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
- **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)

3.32 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.

- **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 Memo June 29,2015

1617_QMR Scoring Descriptors_CVCRR_FINAL_Ancillary

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

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 (2012) 2.A.1.b
- CARF (2012) 2.A.20
- Medicaid Provider Manual 13.3

SECTION 6 – DOCUMENTATION TO SUPPORT SERVICE PROVIDED

6.1 Progress notes show that the frequency and amount of the service is implemented as indicated 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
- DCH Protocol C.2.4

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 wks 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 15 min service, as they can be seen 2x a day (although in this case there should be 2 progress notes in record)

0 Missing documentation
comment: double check that this is not just a date documentation error (typo error); plan of action: if it is, action plan should be as stated above

Source Requirement:

- MDHHS Provider Manual Section 16.2 State Law
- MDHHS Provider Manual Section 15.1 Record Retention
- SWMBH Operating Policy 12.11.III

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

Source Requirement:

- MDHHS PIHP Contract-Person Centered Planning guidelines
- MDHHS Protocol C.2.4
- SWMBH Operating Policy 12.11.III
- CARF (2012) 2.C.8

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
- Medicaid Provider Manual 16.2 State Law
- MDHHS PIHP - PIHP Reporting Requirements p19 of 67
- CARF (2012) 2.C.8
- SWMBH Operating Policy 12.11.III

6.5 Specific interventions/activities used by staff are recorded in each progress note.
Include descriptions of how the staff and/or service is helping work on these goals/objectives.

2 Interventions/activities are documented on all or nearly all progress notes
1 Interventions/activities are overly general or not clearly documented
0 Little or no documentation of interventions/activities in the progress notes

Source Requirement:
- MDHHS PIHP Contract Attachment P.4.4.1.1 Person-Centered Planning Policy & Practice Guideline
- SWMBH Operating Policy 12.11.III
- CARF (2012) 2.C.4
- CARF (2012) 2.C.8

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
CONSULTATIVE RECOMMENDATION: use of specific code applicable to the actual place of service
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.

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***
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:
- CARF 2.C.8
- KCMHSAS Procedure 36.01_01 (Record Access and Entries)
- 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 Fully completed, signed and made available in the record past required date but within 30 days of the date of service
0 Fully completed, signed and made available in the record past 30 days

Source Requirement:
- CARF 2.C.8
- KCMHSAS Procedure 36.01_01 (Record Access and Entries)
- SWMBH Operating Policy 12.11.III

6.10 If applicable, there is a counter signature of the appropriate, credentialed person supervising individual and dated as appropriate.

2 Clear evidence that the documentation of the claimed service was countersigned by the appropriately credentialed supervising individual
1 N/A
0 No evidence in the record that the documentation of the claimed service was countersigned by the appropriately credentialed supervising individual

Source Requirement:
- CARF 2.C.8
- MDHHS PIHP Contract Attachment P.4.4.1.1 Person-Centered Planning Policy & Practice Guideline

6.11 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 (2012) 2.C.8
- 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

6.12 There is evidence of the provider implementing behavior management plans, when applicable, consistently as directed in Behavior Management Plan.

2 Consistent documentation is present and clearly demonstrates that supports / services are provided in accordance with the Behavior Management Plan and the Assessment / Evaluation / Plan
1 Documentation does not clearly demonstrate implementation as written in the behavior management plan 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 (2012) 2.C.8
- 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

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.)

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 (2012) 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 (2012) 2.E.4
- Provider Contractual Agreement Section a

1617_QMR Scoring Descriptors_CVCRR_FINAL_Ancillary

SECTION 10 – PERSON SERVED INPUT/FEEDBACK

10.1 Feedback of person served/guardian on his/her progress toward goal achievement, provider satisfaction and service efficacy is documented in the record on an ongoing basis corresponding with the intensity of the service (at least quarterly).

Feedback can be documented in progress notes and plan reviews. Please include direct quotes from the individual served when possible.

2 Frequent feedback, on both satisfaction with services and progress towards goals and objectives, found in the record (consumer quotes preferred)

1 Feedback is documented fewer than four times a year or consistently missing some elements

0 No feedback on progress/efficacy documented

Source Requirement:

- Medicaid Provider Manual (Mental Health/Substance Abuse Section 2.1)
- MDHHS Protocol C.1.4
- KCMHSAS Policy 33.01 (Person/Family-Centered Planning Process)
- KCMHSAS Policy Exhibit 33.01A (MDHHS Person Centered Planning Best Practice Guidelines)

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
FY 16/17 - CLAIMS VERIFICATION / CLINICAL RECORD REVIEW

Date of Review:

Individual's Name:

Case #:

Population:

Insurance: Medicaid | Medicaid/ Medicare | Other

Provider:

Primary Clinician:

Type of Review: ***Ancillary***

Reviewer: Credentials:

Primary Service:

ACT	Outpatient Therapy	Supported Employment
Crisis Residential	Psychiatry	Targeted Case Management
Homebased	Supports Coordination	Wrap Around

Service Reviewed:

ACT	Homebased	Specialized Residential (CLS/PC)
Access	Outpatient Therapy	Supports Coordination
CLS	Physical Therapy	Supported Employment
Club House	Psychiatry	Targeted Case Management
Crisis Residential	Respite	Wrap Around
E / M	Skill Building	

SECTION 1 - PRIMARY ASSESSMENT		***Possible***	***Actual***
1.5 A current assessment from the primary provider is found in the record.			
Comments:	***N/A***	***0***	***0***

SECTION 3 - INDIVIDUAL PLAN OF SERVICE (IPOS)		***Possible***	***Actual***
3.1 There is a current and complete IPOS in the record.			
3.5 The claimed service was identified in the Individual Plan of Service and/or through Addendum.			
3.25 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.			
3.27 When a provider is implementing interventions from specific care protocols (seizure, BM, special diet, OT/PT, etc.) there is a current assessment/evaluation and service plan in the record.			
3.32 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.			
Comments:	***N/A***	***0***	***0***

SECTION 5 - COORDINATION OF CARE		***Possible***	***Actual***
5.1 There is documented evidence of ongoing contact between the primary clinician and the ancillary provider.			
Comments:	***N/A***	***0***	***0***

SECTION 6 - DOCUMENTATION TO SUPPORT SERVICE PROVIDED	***Possible***	***Actual***
6.1 Progress notes show that the frequency and amount of the service is implemented as indicated in the IPOS.		
6.2 Documentation in the record supports the date of service submitted on the claim.		
6.3 Progress notes reflect back to specific goals/objectives implemented in the IPOS.		
6.4 Documentation in the record supports the number of units submitted on the claim with start and stop times as required.		
6.5 Specific interventions/activities used by staff are recorded in each progress note.		

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
FY 16/17 - CLAIMS VERIFICATION / CLINICAL RECORD REVIEW

Date of Review:

Individual's Name:

Case #:

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	If applicable, there is a counter signature of the appropriate, credentialed person supervising individual and dated as appropriate.		
6.11	There is evidence of the provider implementing auxiliary plans, when applicable, consistently as directed (PT, OT, Care Plan Protocols, Special Diet, etc.).		
6.12	There is evidence of the provider implementing behavior management plans, when applicable, consistently as directed in Behavior Management Plan.		
Comments:		***N/A***	***0***

SECTION 8 - MEDICAL (MEDICATION MANAGEMENT)		***Possible***	***Actual***
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.)		
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].)		
Comments:		***N/A***	***0***

SECTION 10 - PERSON SERVED INPUT / FEEDBACK		***Possible***	***Actual***
10.1	Feedback of person served/guardian on his/her progress toward goal achievement, provider satisfaction and service efficacy is documented in the record on an ongoing basis corresponding with the intensity of the service (at least quarterly).		
Comments:		***N/A***	***0***

Claim ID	Funding Source for Claim	DOS Billed DOS Doc'd	POS Billed POS Doc'd	Code Billed Code Doc'd	Units Billed Units Doc'd	Amount Billed Amount Paid	Doc Signed & Dated	Doc Dated Timely	Recoup Code (see below)	Recoup Amt
Comments:										
Comments:										
Comments:										

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
FY 16/17 - CLAIMS VERIFICATION / CLINICAL RECORD REVIEW

Date of Review:

Individual's Name:

Case #:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Total Recoupment:

Medicaid $0.00

General Fund $0.00

Recoupment Codes:		
	0 = none	5 = overlapping time
	1 = no documentation	6 = incorrect number of units
	2 = no start/stop time	7 = incorrect code
	3 = inadequate documentation	8 = unauthorized service
	4 = duplicate service billed	

OVERALL COMPLIANCE

	Possible	Actual	%
SECTION 1 - PRIMARY ASSESSMENT	*0*	*0*	*N/A*
SECTION 3 - INDIVIDUAL PLAN OF SERVICE (IPOS)	*0*	*0*	*N/A*
SECTION 5 - COORDINATION OF CARE	*0*	*0*	*N/A*
SECTION 6 - DOCUMENTATION TO SUPPORT SERVICE PROVIDED	*0*	*0*	*N/A*
SECTION 8 - MEDICAL (MEDICATION MANAGEMENT)	*0*	*0*	*N/A*
SECTION 10 - PERSON SERVED INPUT / FEEDBACK	*0*	*0*	*N/A*
OVERALL SCORE	*0*	*0*	*N/A*

Yes	No	
		Reviewer requests a Master Level, Licensed Clinician conduct an additional review to determine if the individual is receiving the appropriate level of care/services.

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
FY 16/17 - CLAIMS VERIFICATION / CLINICAL RECORD REVIEW

Date of Review:

Individual's Name:

Case #:

Comments: