Integrated Services of Kalamazoo
Claims Verification / Clinical Record Review
FY 2020/21 - SCORING DESCRIPTORS

		Psych Ancillary	Psychiatric services when individual has a different primary clinician
Section 4 - Individual Plan of Services (IPOS)			
4.1	There is a current, complete IPOS, signed by all necessary parties (consumer / guardian and primary clinician) in the record.	**X**	

Scoring

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*

Section 6 - Coordination of Care			
6.1	There is documented evidence of ongoing contact between the primary clinician and the ancillary provider.	**X**	

- ***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.***

	Psych Ancillary

Scoring

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

- *ISK policy 31.07 (Recovery-Based Services)*
- *CARF (2017) 2.A.7.a*
- *CARF (2017) 2.A.7.b*

Section 7 - Documentation To Support Services Provided

7.1	Progress notes show that the frequency and amount of all identified and authorized services are implemented as indicated in the IPOS. Services must be provided at a level noted in the treatment plan.	**X**

- ***Primary Providers - reviewers will check SmartCare to ensure that ALL services are provided and billed at the frequency described in the IPOS.***
- ***Ancillary Providers - reviewers will check consumer record to ensure authorized service is provided according to plan.***

Scoring

2 Documentation demonstrates that the frequency and amount/duration of contacts is consistent with the IPOS, or within plus or minus 30% of the amount indicated. 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 or provided below plus or minus 30% of the amount indicated, 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*

7.2	Documentation in the record supports the date of service submitted on the claim.	**X**

Scoring

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

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		Psych Ancillary

Source Requirement
- *MDHHS Provider Manual Section 15.7 Clinical Records*
- *MDHHS Provider Manual Section 15.1 Record Retention*
- *SWMBH Operating Policy 12.11.III*

7.3	Progress notes reflect back to specific goals/objectives implemented in the IPOS.	**X**

- ***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.).***

Scoring

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 (2017) 2.C.7*

7.4	Documentation in the record supports the number of units submitted on the claim with start and stop times as required.	**X**

Scoring

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*

7.5	Specific interventions/activities used by staff are recorded in each progress note.	**X**

Scoring

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 the interventions/activities in the progress notes

Source Requirement
- *SWMBH Operating Policy 12.11.III*
- *CARF (2017) 2.C.4*
- *CARF (2017) 2.C.7*

7.6	Evidence-based practices identified in the IPOS are implemented at the intervention level, appropriateness, and technique to support the model. Progress notes should demonstrate the use of those specific techniques.	

Scoring

2 Progress notes consistently demonstrate the use of specific techniques at the intervention level supporting the model for the Evidence-based practices identified in the IPOS.

1 Progress notes did not consistently demonstrate the use of specific techniques at the intervention level supporting the model for the Evidence-based practices identified in the IPOS.

		Psych Ancillary
0	Progress note do not demonstrate the use of specific techniques to support the Evidence-based practice model.	

Source Requirement

- *Medicaid Provider Manual*
- *CARF (2017) 2.H.4*

7.7	The place of service reported on the claim is supported by documentation in the record.	**X**

- ***Actual POS should be utilized (i.e., used code "99" for services that happened in the community, instead of "12") or use MDHHS mandated POS for certain specific service codes (, H2015, H2016). See ISK Memo/POS Chart for further clarification.***

Scoring

2 Used accurate POS code.
1 N/A
0 Used inaccurate or invalid code

Source Requirement

- *SWMBH Operating Policy 12.11.III*
- *EDIT documents 2016*

7.8	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**

Scoring

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 (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:
- 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 - Recovery progress can be documented in a variety of ways and, at a minimum, should be documented on at least a monthly basis.
0 - The documentation process, regardless of the established frequency or process, should be streamlined to minimally disrupt the work-ordered day.

Source Requirement

- *ISK Procedure 36.01_01 (Record Access)*
- *Medicaid Provider Manual*
- *CARF (2017) 2.C.7*
- *SWMBH Operating Policy 12.11.III*

		Psych Ancillary
7.9	The service documentation was fully completed, signed and made available in the record within 3 business days from date of service or 7 days post receiving dictation. (this includes valid signature by rendering clinician/staff).	**X**

Scoring

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 (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 - Recovery progress can be documented in a variety of ways and, at a minimum, should be documented on at least a monthly basis.

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- *CARF (2017) 2.C.7*
- *SWMBH Operating Policy 12.11.III*

Section 9 - Medical (Medical Management)

9.4	Releases of Information for treating physicians (PCP, Specialists as applicable) are updated annually, completed correctly and in the record.	**X**

- ***For Direct Op - MDHHS 5515 Release of Information form is the only form to be utilized with specific providers listed. "Doctor," "Hospital," "Pharmacy" is not acceptable; specific names/titles are to be listed on the Release.***
- ***A release of information for the Primary Care Physician should be present, specifically naming the individual Doctor and/or clinic. If there is no release, there should then be a Document signed by the Person served indicating Coordination of Care with Physician was offered and declined.***

- ***Score only for Psych Services if Psych Services is Primary***

Scoring

2 A current and signed release is present OR a signed form indicating coordination of care was offered and declined is present

1 Clinician has written that coordination of care was declined OR that the individual has no PCP, but the individual's signature is not present on that statement

0 No documentation of consumer's agreement to coordinate care with his/her primary care physician or release has expired without evidence of effort to renew

		Psych Ancillary

Source Requirement

- *ISK policy 40.02 (Coordination with Primary Care Physician)*
- *MDHHS Protocol D.6.3*
- *CARF (2017) 2.G.4*

Section 10 - Psychiatric

10.1	Psychiatric Evaluation includes 1) presenting problem; 2) history of the present illness; 3) previous psychiatric, physical and medication history; 4) relevant personal and family history; 5) a list of all current prescription medications; 6) personal strengths and assets; and 7) a mental status examination.	**X**

- ***Applicable to Primary service providers who provide psychiatric services.***
- ***Only Score the Psych eval if it was completed in the last year. also, mid-levels (Physician Assistants, Nurse Practitioners) are not able to do Psychiatric Evaluations, they have to be completed by a psychiatrist***
- ***If the eval is over a year old - N/A***
- ***Intensive Crisis Stabilization: only score if 9.1 is scored***

Scoring

2 All listed elements present
1 Most listed elements present
0 Most or all listed elements not present

Source Requirement

- *Medicaid Manual MHSA 3.3*
- *ISK Procedure 44.02_03 (Medication / Psychiatric Review)*

10.2	A Psychiatric Evaluation concludes with a written summary based on a recovery model of positive findings and includes 1) a biopsychosocial formulation and diagnostic statement; 2) an estimate of risk factors, including the status of safety issues/risky choices relating to substance use/abuse; 3) initial treatment recommendations; 4) an estimate of length of stay when indicated; and 5) criteria for discharge.	**X**

- ***Applicable to Primary service providers who provide psychiatric services.***
- ***ONLY score the Psych eval if it was completed in the last year. Also, mid-levels (Physician Assistants, Nurse Practitioners) are not able to do initial Psychiatric evaluations, they have to be completed by a psychiatrist.***
- ***Intensive Crisis Stabilization: only score if 9.1 is scored***

Scoring

2 All listed elements present
1 Most listed elements present
0 Most or all listed elements not present

Source Requirement

- *Medicaid Manual MHSA 3.3*

10.3	There is evidence that the individual received education about medications concerning possible side effects and a written consent is signed by the physician or RN for each medication that includes the right to withdraw the consent and the therapeutic dosage range included into the record and is updated at least annually.	**X**

- ***Applicable to Primary service providers who provide psychiatric services.***
- ***The individuals served are to sign medication consent and the physician or RN who provided information about the medication to the person should also sign the document. One effective way of documenting education about medications is to build the side effect handout into the consent form signed by the individual served.***
- ***Intensive Crisis Stabilization: only score if 9.1 is scored***

		Psych Ancillary

Scoring

2 A consent form, with appropriate signatures, and evidence that education and side effects was provided, is present for each medication prescribed

1 Evidence of education about medications and signed consents are present for some, but not all, medications prescribed OR the consent is signed by the individual served but not signed by a physician or RN

0 Medication consents not present or do not contain the individual's signature. No evidence that education about the medications and relevant side effects was provided

Source Requirement

- *ISK policy 44.02 (Pharmacotherapy)*

10.4	A review of medications used by the individual in the past identifies effectiveness, side effects, allergies or adverse reactions.	**X**

- ***Applicable to Primary service providers who provide psychiatric services.***
- ***Item scored only for providers who provide psychiatric services directly and is based on documentation from the prescriber.***
- ***Intensive Crisis Stabilization: only score if 9.1 is scored***

Scoring

2 The review of past medications with discussion of efficacy/side effects/allergies is present

1 The file includes a list of allergies, or states there are no known allergies, but there is no indication of medications previously tried

0 No documentation of past medications or allergic reactions

Source Requirement

- *ISK policy 44.02 (Pharmacotherapy)*
- *CARF (2017) 2.E.5*

10.5	Medication monitoring occurs based on the Prescriber's treatment plan and clinical judgment and is documented in the clinical record.	**X**

- ***Applicable to Primary service providers who provide psychiatric services.***

Scoring

2 Quarterly monitoring is completed

1 Monitoring is completed less than four times per year

0 No evidence of medication reviews

Source Requirement

- *ISK policy 44.02 (Pharmacotherapy)*
- *MDHHS Protocol D.3.2*
- *Medicaid Provider Manual 3.16*
- *CARF (2017) 2.E.5*

10.6	AIMS are completed as required (applicable to Primary service providers who provide psychiatric services).	**X**

- ***Item scored only for providers who provide psychiatric services directly and is based on documentation from the prescriber.***
- ***Intensive Crisis Stabilization: only score if 9.1 is scored***

Scoring

2 AIMS is completed as required

1 AIMS is completed, however not as required

0 No evidence of AIMS completion

Source Requirement

- *MDHHS Protocol D.3.2*
- *ISK policy 44.02 (Pharmacotherapy)*
- *CARF (2017) 2.E.5*
- *Medicaid Provider Manual 3.17*