Medical Record Reviews FY 2020-21
Trending Questions Summary
AOA and CYF Programs
1st Quarter

		Overall Compliance CYF	Overall Compliance AOA
	Number of programs reviewed	**10**	**12**
	Number of charts reviewed	**60**	**114**
	PROVIDER COMPLIANCE		
1	A/OA quarterly Utilization Review Committee (URC) process is documented and record is maintained, reviewing a minimum of 5 clients.	**100%**	**92%**
2	Program Integrity evidence has been reviewed and is in compliance? (P&P review, evidence of paid service verification)	**100%**	**100%**
3	There is evidence that demonstrates program is self monitoring billing and documentation? (include a review of program self disallowances and corrections to claiming.)	**100%**	**100%**
4	Notice of Adverse Benefit Determinations have been reviewed and is in compliance - (Has the program issued any NOABDs in the current fiscal year? Does program have a tracking and monitoring system to ensure NOABDs are given appropriately to clients.) (review forms, logs, policy)	**100%**	**92%**
	ASSESSMENT		
1	Demographic form is completed and previous information is reviewed/updated within 30 days of program assignment.	**88%**	**91%**
2	Demographic form is updated if there was a change in client information after admission and at a minimum annually.	**90%**	**64%**
3	Initial Behavioral Health Assessment (BHA) was completed in its entirety and final approved within 30 calendar days of program assignment (date of assignment counts as day one).	**90%**	**98%**
4	In the BHA covering the review period, the BHA was updated as indicated or at a minimum of annually from previous BHA final approval date.	**96%**	**77%**
5	In the BHA covering the review period, presenting problem documents how client meets or continues to meet medical necessity.	**97%**	**96%**
6	In the BHA covering the review period, documentation evidences a cultural formulation which includes an understanding of how or if culture impacts client's mental health.	**87%**	**89%**
7	In the BHA covering the review period, the Domestic Violence questions have been assessed and answered.	**100%**	**99%**
8	In the BHA covering the review period, the Trauma questions have been assessed and answered.	**91%**	**98%**
9	If past or current substance use is identified, all fields in the substance use table are completed.	**32%**	**72%**
10	In the BHA covering the review period, past and current substance use and its impact on client functioning is documented and diagnosed, if applicable.	**73%**	**96%**
11	In the BHA covering the review period, if any item on the PRA is marked "yes," the Overall Risk and Treatment Planning Section is completed.	**81%**	**79%**
12	In the BHA covering the review period, on the PRA if any questions with an asterisk are answered "yes" there is documentation of review and creation of a safety plan with a clinical supervisor/designee.	**71%**	**58%**
13	Within the past year (from date of current MRR), when a client has discharged from a 24 hour facility (Hospital, Crisis House) for DTS/DTO, a High Risk Assessment (HRA) is completed within 72 hours of discharge.	**50%**	**78%**
14	In the BHA covering the review period, documentation indicates client was asked if he/she has a primary care physician (PCP). If client does have PCP, contact information is included or reason documented why not.	**100%**	**100%**
15	In the BHA covering the review period, if client does not have a PCP, client was advised to seek a PCP.	**100%**	**95%**
16	The BHA covering the review period includes a clearly substantiated Title 9 primary diagnosis.	**97%**	**99%**
17	Clinical Formulation documents that Diagnosis Form has been reviewed if diagnosis is unchanged. If making a new diagnosis, the Diagnosis Form is updated to reflect this change.	**96%**	**94%**
18	In the BHA covering the review period, the Clinical Formulation describes how client's individualized symptom(s) cause current functional impairment (identify areas of client's life that are affected as a result of their mental health diagnosis).	**95%**	**89%**
19	In the BHA covering the review period, the Clinical Formulation documents proposed plan of care/services to address the client's behavioral health needs.	**97%**	**90%**

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	CLIENT PLAN (CP) **Program is expected to have a current Client Plan for the review period. Without, those items on the tool will be recorded as "no" regardless of a previous client plan and services may be disallowed.**		
20	Initial Client Plan was completed and final approved within 30 days of program assignment (date of assignment counts as day one) and contains all required signatures or reason documented why not signed.	**91%**	**97%**
21	An updated Client Plan covering the review period was completed and final approved annually (or at UM, whichever comes first, for CYF only) and contains all required signatures or reason documented why not signed.	**78%**	**59%**
22	For CYF programs only, Client Plan contains CANS Sharing Confirmation Page as indicated.	**95%**	**100%**
23	Documentation evidences that the Client Plan was explained to the client or family/legal guardian in his/her primary language.	**100%**	**100%**
24	Documentation evidences that the client or family/legal guardian was offered a copy of the plan or reason why not offered.	**100%**	**100%**
25	The Client Plan covering the review period is documented with specific client strengths that are applied to support client goals and objectives.	**98%**	**96%**
26	The Client Plan covering the review period includes an Area of Need(s) which documents current symptoms, behaviors, and level of impairment affecting life functioning that support the diagnosis for the focus of treatment.	**94%**	**91%**
27	The Client Plan covering the review period includes objectives that are client specific, observable and measurable.	**77%**	**63%**
28	The Client Plan covering the review period documents frequency for all Interventions.	**97%**	**98%**
29	The Client Plan covering the review period documents duration for all Interventions.	**99%**	**98%**
30	The Client Plan Interventions are documented with specific language that focuses on client's individual symptoms, behaviors and/or functional impairments as identified in the Area of Need. Documentation will evidence how intervention will 1) diminish impairment, or 2) prevent deterioration, or 3) allow developmental progress of child.	**76%**	**71%**
31	For the Client Plan covering the review period, if risk factors of harm to self or others have been identified, there is evidence that the issues are addressed on the Client Plan.	**93%**	**88%**
32	For the Client Plan covering the review period, if a Substance Use Disorder has been identified and diagnosed as an ongoing problem for client's mental health, there is evidence that the issues are addressed on the Client Plan or reason for omission is documented.	**100%**	**95%**
33	For the Client Plan covering the review period, if physical health needs that affect the client's mental health have been identified, there is evidence that the needs are addressed on the Client Plan or reason for omission is documented.	**100%**	**95%**
	PROGRESS NOTES AND FORMS		
34	Progress notes document client's impairment(s) in functioning as a result of a mental health diagnosis.	**100%**	**99%**
35	Progress notes document specialty mental health intervention(s) utilized to address the impairment(s) and supports the client plan objective(s).	**100%**	**97%**
36	Progress notes document recipient's response to the specialty mental health intervention(s).	**100%**	**99%**
37	For clients identified at risk, progress notes document ongoing risk assessment, clinical monitoring, and intervention(s) that relate to the level of risk.	**100%**	**99%**
38	For clients diagnosed with a co-occurring substance use disorder that is included on the client plan, progress notes document specific integrated treatment approaches.	**90%**	**100%**
39	For clients with physical health needs related to their mental health treatment, progress notes document that physical health care (education, resources, referrals, managing health symptoms) is integrated into treatment.	**100%**	**96%**
40	For clients assessed as having an urgent psychiatric condition, urgent services are provided by a mental health professional within 48 hours, or documented why not.	**100%**	**80%**
41	Documentation evidences coordination of care (communication, Tx updates, and/or referrals) between the program and client's other service providers and/or significant support person(s).	**100%**	**96%**
42	Coordination with Primary Care Physicians and Behavioral Health Form is completed within 30 days of assignment and evidences coordination with, or documented reason why not completed.	**75%**	**72%**
43	For clients prescribed psychotropic medication by the program, there is an "Informed Consent for the Use of Psychotropic Medication" form signed by both client or family/legal guardian and psychiatrist. The use of the current form is required.	**100%**	**94%**
44	The "Informed Consent for the Use of Psychotropic Medication" have been completed with all fields documented. The use of the current form is required.	**75%**	**83%**

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45	Medical staff is entering client medications, medical conditions and vitals into CCBH Medical Conditions tab or Doctor's Home Page (DHP).	80%	72%
46	For clients prescribed controlled substances, there is documentation that the CURES database is reviewed upon initial prescription and at least once every 4 months thereafter if the substance remains part of the treatment plan.	#DIV/0!	100%
47	The Youth Transition Self-Evaluation (YTSE) form had been completed for CYF clients 16 years old, 17, 17 ½, 18 and annually thereafter.	50%	100%
	BILLING		
48	Paper Progress Note includes service code, date of service, service time, date of documentation, signatures, job title/degree, and printed name.	100%	100%
49	Service Code billed matches service code on Paper Progress Note.	100%	100%
50	Time billed is equal to time documented on Paper Progress Note.	100%	100%
51	Service Code is correct for service documented.	89%	70%
52	Time billed is substantiated in documentation. (Time claimed should be reasonably evident in the progress note including face to face, travel and documentation time.)	69%	72%
53	Service time is claimed accurately to the minute as there is no trend or pattern of services being rounded or "same time" claimed for face to face, travel and documentation time across progress notes.	93%	90%
54	Selection for all Billing Indicators are correct (i.e. Person Contacted, Place of Service, Contact Type, Appointment Type, Billing Type, Service Intensity Type).	48%	61%
55	Progress Notes are final approved within 14 calendar days from date of service. (Date of service counts as "day one".)	81%	84%
56	Services provided involving more than one server, document the clinically compelling or medically necessary reason for more than one server (Applies to group and individual services).	100%	100%
57	Services provided involving more than one server, document the clinical therapeutic intervention of each server (Applies to group and individual services).	100%	100%
58	Documentation for all services provided in the review period evidences service was provided within the scope of practice of the server.	100%	100%
59	All non-billable 800 codes are used appropriately (e.g., post 14 days, no valid Client Plan, supportive service that is not a Specialty Mental Health Service).	82%	79%
60	Services are billable according to Title 9 (e.g., no progress note, no-shows, lock-outs, non-billable activities, medical necessity, etc.).	77%	70%
	UTILIZATION MANAGEMENT/REVIEW		
61	During the review period, UM/UR due date and documentation requirements (UR/UM Auth forms, CPs) are completed as required.	93%	86%
62	Outcome measures are completed and entered into database within timelines. (Program will be asked for evidence of entry into database.)	82%	52%
63	For CYF programs only. Any CANS outcome with a Need rating of "2 or 3" has supporting indicators referencing the BHA.	98%	na
64	If utilizing SC83 Intensive Home Based Services, approved authorization form from Optum will be filed in hybrid chart.	81%	na
	Pathways to Well-Being (PWB)		
65	If client has an open CWS case, Eligibility for PWB and Enhanced Services form is completed in CCBH and updated within required timelines.	89%	na
66	Progress Report to Child Welfare Services form is completed and updated within appropriate timelines and form indicates that CANS were shared with CWS, or reason documented why not.	51%	na
67	If client has an open CWS case, documentation of PWB Subclass or PWB Class status is noted in the BHA for the review period.	97%	na
68	If client has an open CWS case, the PWB identifier for Subclass or Class is indicated in Client Categories Maintenance.	79%	na
69	If utilizing SC 82 Intensive Care Coordination or SC 83 Intensive Home-Based Services, Client Plan has required interventions added.	95%	na
70	Documentation supports that a CFT (Child Family Team) meeting has occurred within 30 days of identification of Subclass on the Eligibility for PWB and Enhanced Services form, and at a minimum of every 90 days thereafter. If CFT meeting timelines are not met, documentation includes a justifiable reason for CFT meeting postponement and efforts to reschedule CFT meeting as soon as possible.	16%	na