Medical Record Reviews FY 2018-19
Trending Questions Summary
AOA and CYF Programs
Q3 FY 2018-19

		Overall Compliance CYF	Overall Compliance AOA
	Number of programs reviewed	**27**	**20**
	Number of charts reviewed	**166**	**155**
	ASSESSMENT **Program is expected to have a current BHA for the review period. If there is no current BHA, those items on the tool will be recorded as "no" regardless of a previously completed BHA.**		
1	Demographic form is completed and previous information is reviewed/updated within 30 days of program assignment.	**97%**	**82%**
2	Demographic form is updated if there was a change in client information after admission and at a minimum annually.	**62%**	**76%**
3	Initial BHA was final approved within 30 calendar days of program assignment (date of assignment counts as day one).	**90%**	**81%**
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.	**90%**	**55%**
5	In the BHA covering the review period, presenting problem documents how client meets or continues to meet medical necessity.	**95%**	**90%**
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.	**93%**	**78%**
7	In the BHA covering the review period, the Sexual Orientation question has been assessed and answered.	**100%**	**96%**
8	In the BHA covering the review period, the Gender Identity question has been assessed and answered.	**100%**	**96%**
9	In the BHA covering the review period, the Domestic Violence questions have been assessed and answered.	**100%**	**95%**
10	In the BHA covering the review period, the Trauma questions have been assessed and answered.	**98%**	**95%**
11	In the BHA covering the review period, past and current substance use and its impact on client functioning is documented and diagnosed, if applicable.	**70%**	**60%**
12	In the BHA covering the review period, if any item on the HRA is marked "yes", the Protective Factors and Self Injury/Suicide/Violence Management Plan fields are completed.	**77%**	**78%**
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.	**92%**	**49%**
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.	**99%**	**96%**
15	In the BHA covering the review period, if client does not have a PCP, client was advised to seek a PCP.	**88%**	**84%**
16	The BHA covering the review period includes a clearly substantiated Title 9 primary diagnosis.	**98%**	**93%**
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.	**93%**	**75%**
18	In the BHA covering the review period, the Clinical Formulation documents how client's symptom(s) impact current functioning.	**91%**	**82%**
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.	**98%**	**94%**

#	Item	Overall Compliance CYF	Overall Compliance AOA
	CLIENT PLAN **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 or final approved.	**91%**	**88%**
21	A new and updated Client Plan covering the review period was written and final approved annually or reviewed at UM (CYF only) and contains all required signatures or reason documented why not signed or final approved.	**78%**	**51%**
22	Documentation evidences that the Client Plan was explained to the client or family/legal guardian in his/her primary language.	**100%**	**98%**
23	Documentation evidences that the client or family/legal guardian was offered a copy of the plan or reason why not offered.	**100%**	**97%**
24	The Client Plan covering the review period is documented with specific client strengths that are applied towards client goals and objectives	**90%**	**81%**
25	The Client Plan covering the review period documents that Area of Need(s) is linked to symptoms/behaviors and level of impairment affecting functioning that were identified in BHA and linked to the diagnosis for the focus of treatment.	**89%**	**87%**
26	The Client Plan covering the review period includes objectives that are specific, observable and measurable.	**85%**	**61%**
27	The Client Plan covering the review period documents frequency for all Interventions.	**89%**	**90%**
28	The Client Plan covering the review period documents duration for all Interventions.	**91%**	**90%**
29	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.	**53%**	**58%**
30	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.	**92%**	**90%**
31	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.	**91%**	**82%**
32	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.	**61%**	**65%**
	PROGRESS NOTES AND FORMS		
33	Progress notes document client's impairment(s) in functioning as a result of a mental health diagnosis.	**97%**	**96%**
34	Progress notes document specialty mental health intervention(s) utilized to address the impairment(s) and supports the client plan objective(s).	**100%**	**96%**
35	Progress notes document recipient's response to the specialty mental health intervention(s).	**100%**	**98%**
36	For clients identified at risk, progress notes document ongoing risk assessment, clinical monitoring, and intervention(s) that relate to the level of risk.	**100%**	**97%**
37	For clients diagnosed with a co-occurring substance use disorder that is included on the client plan, progress notes document specific integrated treatment approaches.	**85%**	**85%**
38	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.	**76%**	**94%**
39	For clients discharged from an inpatient/crisis residential facility, documentation evidences client was assessed in a timely manner, and if urgent service needed, client was seen by a mental health professional within 48 business hours, or documented why not.	**100%**	**70%**
40	Documentation evidences coordination of care (communication, Tx updates, and/or referrals) between the program and client's other service providers (community therapist, FFS psychiatrist, primary care physician, day treatment, case management, school, child welfare, foster care, family/caregivers, or other agencies).	**91%**	**91%**
41	Coordination with Primary Care Physicians and Behavioral Health Form is completed and evidences coordination with, or documented reason why not completed.	**80%**	**58%**
42	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.	**85%**	**94%**
43	The "Informed Consent for the Use of Psychotropic Medication" have been completed with all fields documented.	**88%**	**76%**
44	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.	**94%**	**100%**
	SURVEY QUESTION ONLY: For A/OA clients prescribed controlled substances, a Patient Medication Agreement form was reviewed and signed by both client and Practitioner. Completed form is filed in hybrid chart.		**100%**

#		Overall Compliance CYF	Overall Compliance AOA
	BILLING		
45	Paper Progress Note includes service code, date of service, service time, date of documentation, signatures, job title/degree, and printed name.	**94%**	**77%**
46	Service Code billed matches service code on Paper Progress Note.	**100%**	**85%**
47	Time billed is equal to time documented on Paper Progress Note.	**95%**	**85%**
48	Service Code is correct for service documented.	**77%**	**70%**
49	Time billed is substantiated in documentation. (Time claimed should be reasonably evident in the progress note including face to face, travel and documentation time.)	**67%**	**60%**
50	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.	**79%**	**89%**
51	Selection for all Billing Indicators are correct (i.e. Person Contacted, Place of Service, Contact Type, Appointment Type, Billing Type, Service Intensity Type, EBP).	**61%**	**75%**
52	Progress Notes are final approved within 14 calendar days from date of service. (Date of service counts as "day one".)	**82%**	**72%**
53	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)	**67%**	**67%**
54	Services provided involving more than one server, document the clinical therapeutic intervention of each server. (applies to group and individual services)	**33%**	**30%**
55	Documentation for all services provided in the review period evidences service was provided within the scope of practice of the server.	**100%**	**100%**
56	All non-billable 800 codes are used appropriately (e.g., post 14 days, no valid Client Plan, supportive service that is not SMHS).	**92%**	**73%**
57	Services are billable according to Title 9 (e.g., no progress note, no-shows, lock-outs, non-billable activities, medical necessity, etc.).	**65%**	**47%**
	UTILIZATION MANAGEMENT/REVIEW		
58	During the review period, UM/UR due date and documentation requirements (UR/UM Auth forms, CPs) are completed as required.	**93%**	**78%**
59	Outcome measures are completed within timelines and entered into database. (Program will be asked for evidence of entry into database.)	**79%**	**43%**
	SURVEY QUESTION ONLY: For CYF programs only. Any CANS outcome with a Need rating of "2 or 3" has supporting indicators referencing the BHA.		
	DAY TREATMENT INTENSIVE/ REHABILITATION (Children's System of Care)		
60	Authorization for Day Program Request (DPR) is completed and approved for services entered within required timelines with accurate dates verified in CCBH.	**100%**	**na**
61	Documentation in BHA covering the review period supports the level of care for Day Treatment, indicating a lack of progress or stabilization in a lower level of care.	**90%**	**na**
62	Daily documentation is present describing Day Treatment Intensive services.	**na**	**na**
63	Weekly summary notes include appropriate boxes marked and dates (M/D/YR) of each day attended with services provided.	**100%**	**na**
64	Weekly summary notes reflect detailed information regarding client impairment, intervention, responses, and progress towards goals which justify billed time throughout the week.	**100%**	**na**
65	Weekly summary notes have been signed/co-signed by licensed/registered/waivered staff.	**100%**	**na**
66	Documentation of at least one psychotherapy contact per week for a Day Treatment Intensive program.	**na**	**na**
67	Documentation of at least one contact a month with family and/or significant support person.	**80%**	**na**
68	Day program has a system in place to ensure that beneficiaries with "unavoidable absences" have met the 50% attendance requirement for reimbursement.	**100%**	**na**
69	Unavoidable absences are explained with absence time being documented accurately and reflected within the Attendance logs.	**60%**	**na**

#	Item	Overall Compliance CYF	Overall Compliance AOA
70	Significant Weekly Information includes examples of Process groups, Skill building groups and Adjunctive therapies provided during the week, including impairment, progress, and response.	50%	na
	Pathways to Well-Being (PWB)		
71	If Client meets criteria for enhanced services, Eligibility for PWB and Enhanced Services form is completed and in CCBH and Progress Report to Child Welfare Services PWB form is completed and in hybrid chart. Both forms are updated according to required timelines.	70%	na
72	If Client meets criteria for enhanced services, documentation of Katie A Subclass or Katie A Class status is noted in the BHA for the review period	100%	na
73	Client is identified in Client Categories Maintenance with the KTA identifier for the subclass or class.	70%	na
74	If subclass eligible, Client Plan has required intervention of SC 82 Intensive Care Coordination (ICC) (and SC 83 Intensive Home Based Services is added if assessment indicates client is to receive IHBS).	81%	na
75	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.	63%	na
76	If CFT meeting timelines are not met, documentation includes clear reason for CFT meeting postponement and efforts to coordinate meeting in the near future.	57%	na
77	When documenting a CFT meeting, the service encounter screen includes entry of the Evidence Based Practice (EBP) indicator "Child Family Team Meeting".	59%	na
	Performance Improvement Project (PIP)		
78	During the review period, did the clinician document in a progress note that they assigned/reviewed therapeutic homework with the client and/or their caregiver? (For data tracking only; item not included in the MRR score)	27%	17%

Medical Record Reviews FY 2018-19
Trending Questions Summary
START Programs
Q3 FY 2018-19

#	Item	Overall Compliance START
	Number of programs reviewed	**6**
	Number of charts reviewed	**27**
	ASSESSMENT **Program is expected to have a current BHA for the review period. If there is no current BHA, those items on the tool will be recorded as "no" regardless of a previously completed BHA.**	
1	Demographic form is completed and previous information is reviewed/updated upon admission and final approved prior to client's discharge from program.	**100%**
2	Initial BHA was final approved prior to client's discharge from the program.	**77%**
3	In the BHA covering the review period, presenting problem documents how client meets or continues to meet medical necessity.	**100%**
4	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.	**97%**
5	In the BHA covering the review period, the Sexual Orientation question has been assessed and answered.	**100%**
6	In the BHA covering the review period, the Gender Identity question has been assessed and answered.	**100%**
7	In the BHA covering the review period, the Domestic Violence questions have been assessed and answered.	**100%**
8	In the BHA covering the review period, the Trauma questions have been assessed and answered.	**100%**
9	In the BHA covering the review period, past and current substance use and its impact on client functioning is documented and diagnosed, if applicable.	**91%**
10	In the BHA covering the review period, if any item on the HRA is marked "yes", the Protective Factors and Self Injury/Suicide/Violence Management Plan fields are completed.	**100%**
11	Within the past year (from date of current MRR), when a client has discharged from a 24 hour facility (Hospital, Crisis House) for a mental health crisis, a High Risk Assessment (HRA) is completed.	**100%**
12	In the BHA covering the review period, BHA documents client was asked if he/she has a primary care physician (PCP).	**100%**
13	In the BHA covering the review period, if client does not have a PCP, client was advised to seek a PCP.	**83%**
14	The BHA covering the review period includes a clearly substantiated Title 9 primary diagnosis.	**97%**
15	In the BHA covering the review period, the Clinical Formulation documents client's symptom(s), and functional impairment(s).	**100%**
16	In the BHA covering the review period, the Clinical Formulation documents proposed plan of care/services to address the client's behavioral health needs.	**100%**
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.	**97%**
	CLIENT PLAN **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.**	
18	Initial Client Plan was completed and contains all required signatures or reason documented why not signed.	**92%**
19	Documentation evidences that the Client Plan was explained to the client or family/legal guardian in his/her primary language.	**92%**
20	Documentation evidences that the client or family/legal guardian was offered a copy of the plan or reason why not offered.	**100%**
21	The Client Plan covering the review period includes a specific goal, that ties to client's symptoms and behaviors.	**100%**
22	The Client Plan covering the review period includes objectives that are specific, observable and measurable.	**100%**

		Overall Compliance START
23	The Client Plan covering the review period documents frequency for all Interventions.	**100%**
24	The Client Plan covering the review period documents duration for all Interventions.(duration is equal to the length of stay)	**100%**
25	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.	**94%**
26	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%**
27	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 diminish impairment, or prevent deterioration.	**100%**
	PROGRESS NOTES AND FORMS	
28	Within each 24 hour documented note, client's impairment(s) in functioning has been documented at least once.	**100%**
29	Within each 24 hour documented note, specialty mental health intervention(s) utilized to address the impairment(s) and support the client plan objective(s) has been documented at least once.	**100%**
30	Progress notes document recipient's response to the specialty mental health intervention(s).	**100%**
31	For clients identified at risk, progress notes document ongoing risk assessment, clinical monitoring, and intervention(s) that relate to the level of risk.	**96%**
32	For clients diagnosed with a co-occurring substance use disorder that is included on the client plan, progress notes document specific integrated treatment approaches.	**100%**
33	Documentation evidences coordination of care (communication, Tx updates, and/or referrals) between the program and client's other service providers (community therapist, FFS psychiatrist, primary care physician, day treatment, case management, school, child welfare, foster care, family/caregivers, or other agencies).	**100%**
34	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.	**84%**
35	The "Informed Consent for the Use of Psychotropic Medication" have been completed with all fields documented.	**95%**
36	For clients prescribed controlled substances, there is documentation that the CURES database is reviewed upon initial prescription.	**100%**
	SURVEY QUESTION: For A/OA clients prescribed controlled substances, a Patient Medication Agreement form was reviewed and signed by both client and Practitioner. Completed form is filed in hybrid chart.	
	BILLING	
37	Paper Progress Note includes service code, date of service, service time, date of documentation, signatures, job title/degree, and printed name.	**72%**
38	Service Code billed matches service code on Paper Progress Note.	**100%**
39	Time billed is equal to time documented on Paper Progress Note.	**92%**
40	Service Code is correct for service documented.	**88%**
41	Time billed is substantiated in documentation. (Time claimed should be reasonably evident in the progress note including face to face, travel and documentation time.)	**100%**
42	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.	**100%**
43	Selection for all Billing Indicators are correct (i.e. Person Contacted, Place of Service, Contact Type, Appointment Type, Billing Type, Service Intensity Type, EBP).	**72%**
44	Progress Notes are signed within 14 calendar days from date of service. (Date of service counts as "day one".)	**100%**
45	Documentation for all services provided in the review period evidences service was provided within the scope of practice of the server.	**100%**
46	Medical Necessity has been documented at least one time during a 24 hour period for each day of stay (can be documented as "at risk for decompensation if discharged early").	**96%**