Provider Alert
April, 2010
Common Audit Findings

OMHC

Audit Item#/Description	Regulation/COMAR/CMS Citation	Area of Deficiency	Recommendation(s)
2. If the consumer is a child for whom courts have adjudicated their legal status or an adult with a legal guardian, are there copies of court orders or custody agreements?	*10.21.17.08 B (10)* *10.21.17.04 A (1)(c)*	Documentation of guardianship is missing • i.e. Court Orders, Custody Agreements	1. For children who have been referred for treatment by the Department of Social Services (DSS) or Department of Juvenile Services (DJS), obtain copies of a court order or a letter from the placement agency that indicates who can consent to treatment on behalf of the minor. 2. Explore options available with DSS to facilitate a voluntary change in custody and/or medical decision-making temporarily, while the parent is unavailable to meet this responsibility. 3. Train intake staff and clinicians on COMAR policies related to consent information.
3. Does the medical record contain a completed MHA Documentation for Uninsured Eligibility Benefit form or Uninsured Eligibility Registration form?	*MHA Guidelines* • Detailed information regarding this requirement is posted on the ValueOptions-Maryland website (http://maryland.valueoptions.com/), "For Providers", "Provider Alerts", "ValueOptions Provider Alerts","2/5/10: Provider Alert-Uninsured Eligibility Documentation".	Records are missing a completed MHA Documentation for Uninsured Eligibility Benefit form or Uninsured Eligibility Registration form.	1. This standard for this item is a MHA requirement and applies to uninsured consumers and the "primary provider of services". In most instances, "primary provider" is an Outcome Measurement System (OMS) provider or Outpatient Mental Health Center (OMHC) who should be responsible for requesting an uninsured eligibility span as necessary. 2. MHA has confirmed that a copy of the Uninsured Eligibility Registration Form in ProviderConnect meets the documentation requirements to validate the consumer's uninsured eligibility. Providers should continue to provide supporting documentation in the consumer's medical record.

			3. Per an October 24, 2008 MHA Memorandum "Clarification on Completing Documentation for Uninsured Eligibility Benefit Form", "…for every individual who is uninsured, programs shall document that applications have been made for all applicable benefits. Programs are to assist consumers by reviewing all potential public benefit programs and referring individuals accordingly. The "Documentation for Uninsured Eligibility Benefit" form is to be kept in the individual's medical record."
4. Is there documentation present indicating that the consumer (over the age of 18) has been given information on making an advance directive for mental health services?	*10.21.17.04 C*	There is no documentation of staff explaining the advanced directive process to the consumer.	1. Provide new and existing adult consumers, verbally and in writing, information regarding creating an Advanced Directive for mental health services. 2. Consider designing a consent form that explains what an advanced directive is, the consumer's options for completing an advanced directive, and how often the consumer will be asked if he/she would like to complete an advanced directive. This form can be incorporated into admissions paperwork for new consumers. Provide a signature and date section to include spaces for the consumer and treatment coordinator to sign. If the consumer declines an advanced directive for mental health services, note the refusal and date in the record. 3. A relapse prevention plan/crisis management plan can serve in the place of a Mental Health Advanced Directive if the plan covers the applicable requirements of an Advanced directive. 4. Refer to the following websites for sample Advanced Directive forms: (MHA-"Public Documents & Forms") www.dhmh.state.md.us/mha and (Bazelon Center) http://www.bazelon.org/issues/advancedirectives. 5. If the consumer has a Mental Health Advanced Directive, include a copy of the document in the record. If the consumer requires assistance with

			completing an advanced directive, assign staff to assist the individual.
9. Was a Substance Abuse Screening Assessment completed?	*10.21.20.06 B*	Records are missing substance abuse screening assessments for adult and adolescent consumers.	1. Complete a scientifically validated and age-appropriate Substance Abuse Assessment on all *new* adolescent and adult consumers. A list of screening tools approved by MHA is attached to the "Corrected COMAR Change Clarification 4/20/08" DHMH memorandum and is located on the ValueOptions® webpage under For Providers/Provider Information/Announcement Archive/2008 (PDF) headings. 2. Prior to the *current* adolescent/adult consumers' next ITP, complete a scientifically validated and age appropriate Substance Abuse Assessment.
10. Is there evidence of integration of, or collaboration with, Substance Abuse services?	*10.21.20.08 D (1)(2)*	There is no evidence of integration of, or collaboration with, substance abuse services.	1. If substance abuse issues are identified, document a substance abuse goal on the ITP. 2. Clearly document referrals for additional assessment or chemical dependency treatment in the record. Train staff to have on-going collaboration with the substance abuse program, whether within the agency or at an outside facility, with consumer consent.
13. Does the medical record document active participation in establishing the goals, objectives, and interventions of the ITP and is it documented that the consumer accepted or declined a copy of the ITP?	*10.21.20.07 A(4)*	The ITP's are missing signature(s) of the consumer, parent/*legal* guardian. The treatment coordinator did not address the consumer's choice to receive a copy of the ITP.	1. Train staff to obtain consumer and his/her parent/*legal* guardian's signature on all treatment plans. These signatures demonstrate active participation in the treatment planning process. 2. Modify the existing ITP template to include a section stating that the consumer was offered a copy of the ITP and whether he/she accepted or declined a copy. Train staff to fully complete all prompts of the ITP, specifically a section related to offering a copy of the ITP to the consumer and consumer response. 3. For best practice and billing of treatment planning services (service code H0032), document in a contact note that treatment planning took place.

15. Does the ITP contain goals/objectives that are individualized, specific and measurable with an achievable timeframe?	*10.21.20.07 A (1)(b)(v)* *CMS State Medicaid Manual Part 4 4221 C*	The treatment goals lack measurability.	1. Train all staff on developing and writing specific and measurable ITP's. Measurements include self report, client rating scales, observable outcomes, percentage to an established baseline, and counting events. The goals/objectives must also be individualized and not the same for each consumer. • E.g. Reframe the goal, "Patient will reduce temper tantrums" to "Patient will decrease number of temper tantrums from 10 times/week to 3 times/week for 4 consecutive weeks as evidenced by self report and parent report of consumer progress on a behavior log".
17. Is an ITP Review completed at a minimum of every 6 months?	*10.21.20.07 A (2)*	ITP reviews have not been completed at a minimum of every 6 months.	Update ITP's at a minimum of every six (6) months.
18. Does the record reflect a transition/discharge plan consistent with the services provided?	*10.21.17.10 C*	There is no transition/discharge plan or all of the required elements of a discharge plan are not present.	1. A plan for discharge and/or transition to a lower level of care must be documented as part of the individualized treatment planning process. 2. The plan should include the following: • the goals that the consumer needs to accomplish in order for the transition/discharge to occur; • the supports needed at time of discharge/transition and; • an estimated timeframe within which the transition will realistically occur. The process of transition/discharge planning must take place on an ongoing basis and should occur at each treatment plan review.
19. Within 10 working days after an individual is discharged from a program, has the consumer's service coordinator completed and signed a discharge summary?	*10.21.17.10 D*	A discharge summary is missing or not completed 10 working days following the consumer's discharge from the agency.	Train staff to complete discharge summaries within 10 working days after the consumer has been discharged from the agency. Sign and date the summary.
20. Does the discharge summary include, at a minimum: reason for admission, reason for discharge,	*10.21.17.10 D (1-8)*	There is no discharge summary in the record or the discharge summary	1. Address all of the following elements when drafting a discharge summary:

services provided, progress made, diagnosis at the time of discharge, current medications, continuing service recommendations and summary of the transition process, and extent of individual's involvement in the discharge plan?		present does not contain all of the required elements.	• reason for admission • reason for discharge • services provided (including frequency/duration of services) • progress made • diagnosis at the time of discharge (if appropriate) • current medications (if any) • continuing service recommendations and summary of the transition process • extent of individual's involvement in the discharge plan.
21. Does the ITP include all required signatures with dates?	*10.21.2007 A (3)*	• ITP's are missing, outdated, or not signed/dated by all responsible parties involved in the consumer's treatment. • E.g. consumer receives therapy and medication management yet the psychiatrist did not sign the plan • E.g. An individual not designated as *legal* guardian signs the ITP.	1. Train all staff to obtain the proper signatures when completing an ITP to include: parent/legal guardian, mental health professional and prescribing psychiatrist (if applicable), along with date and credentials/title. 2. At least two licensed mental health professionals who collaborate about the individual's treatment must sign the plan and reviews.
23. Are the Contact notes complete?	*10.09.59.03 J(1)(2)(3)(4)* *10.21.20.07 B (1)(e)(f)(g)* *CMS State Medicaid Manual Part 4 4221 D 6*	Contact notes do not contain all of the following items: • date • start time/end time or start time/duration • chief medical complaint/reason for the visit • consumer's mental status • the delivery of services specified by the ITP • a brief description of the service provided • the plan for changes in treatment (if any)	1. Train staff on the required components of a contact note. Monitor staff compliance with completing notes following a therapy session. 2. Train staff that signatures must be legible and accompanied by their name and credentials (hand-printed or stamped) and the date. 3. Monitor documentation in contact/progress notes by conducting quarterly inter-agency audits of medical records.

		• the consumer's progress towards goals • and a legible signature with job title or MH professional license (if applicable).	
27. Is there documentation of the consumer's past and current somatic/medical history and documentation of ongoing communication and collaboration with the PCP?	*10.21.20.06 D*	There is no documentation regarding the consumer's somatic status, nor is there communication/collaboration with the consumer's PCP (or no referral to for a PCP).	1. Should a consumer have somatic concerns and when clinically indicated, document all efforts of forwarding information to the PCP pertaining to the consumer's treatment, with appropriate consent. 2. Any time information is faxed to the PCP, include either the fax cover sheet in the medical record; document any verbal communication exchange with the PCP or his/her staff on an external communication log. 3. Assist those consumers who do not currently have a primary care physician, with a referral to one. Document these linkage efforts in the chart.

PRP-Adult

Also see comments under OMHC heading related to:

- **Advanced Directives for Mental Health Services**
- **Goal Measurability**
- **Transition/Discharge Planning**
- **Required signatures on plans**
- **Submission of Discharge Summaries**
- **Collaboration with the PCP**

Audit Item#/Description	Regulation/COMAR/CMS Citation	Area of Deficiency	Recommendation(s)
1. Has the PRP documented the consumer's eligibility for Federal or State entitlements and assisted the individual in applying for all entitlements for which he/she may be eligible?	*10.21.21.05 C (1-3)*	Entitlement information is not documented in the record.	1. Train staff to document that the consumer has entitlements or document efforts to assist the consumer in obtaining entitlements for which he/she may be eligible. Examples of entitlement data include: • Copies of Supplemental Security Income Determination letters • Dept. of Social Services award letters • Food stamps • Family Income Supplements • Adoptive Benefits • Transitional Emergency • Medical and Housing Assistance (TEMHA) program forms • MD Disability Determination Services letters. 2. Consider adding a section to the Rehabilitation Assessment that addresses entitlements (i.e. type of assistance/award, amount of funding, etc.).
7. When required, does the consumer record document the consumer's choice to receive only off-site or only on-site	*February 2004 Issues Bulletin*	An on/off site consent is missing from the file and the consumer *only* received off-site services as evidenced by a review of	1. Ensure that all consumers are advised of their choice to receive on-site services only, off-site services only, or a combination of

PRP services?		contact notes for audited months of service. Also, per review of billing records, the agency bills the blended rate.	both on- and off-site services. 2. Document consumer choice on a consent form and have the consumer sign and date the form. For best practice, an on/off site consent should be in all records, even if the consumer receives a combination of on- and off-site PRP services on a routine basis.
8. Was a screening assessment completed within ten (10) working days of the program's receipt of a PRP referral to determine medical necessity for rehabilitation services?	*10.21.21.05 B*	A screening assessment was not completed within 10 working days after receipt of a PRP referral. The screening assessment was completed prior to the official referral. The screening was completed prior to the date the consent was signed. Staff utilizes a combined screening/rehabilitation assessment which is poorly written and fails to address the need for PRP services and is not completed within 10 days.	1. Train staff to clearly document actual date of consumer referral to the PRP. A consumer should be formally referred to the PRP prior to the screening assessment taking place. 2. Train staff to complete screening assessments within 10 working days of receipt of a referral to both identify consumer need and determine services required.
9. Is there a comprehensive PRP Rehabilitation Assessment that was completed within 30 calendar days of initiation of PRP services?	*10.21.21.06 B* *CMS State Medicaid Manual Part 4 4221 B*	There is no Rehabilitation Assessment in the record. The Rehabilitation Assessment is not completed within the required timeframe. The Rehabilitation Assessment is present, but missing some of the required elements of the MHA regulatory standards for assessments.	The Rehabilitation Assessment must contain the individual's strengths, skills, wants, and needs in the following areas: • Independent living; • Housing; • Employment; • Self administrations and management of medication; • Mobility and transportation; • Social relationships and leisure activities; • Education and vocational training; • Adaptive equipment or resources; and • Other factors that may pose a challenge to the individual's successful recovery and rehabilitation; • Current resources and support system;

			• As relevant, a review of the individual's legal status and forensic history, if any; • The individual's history of substance abuse, if any; • Behaviors, if any, that are potentially dangerous to the individual or others. For individuals receiving RRP services, assess the following: • Need for RRP services • Ability to perform basic self-care and maintenance of personal safety • Need for changing intensity of intervention based on episodic nature of mental illness.
10. Was an initial IRP completed within 30 calendar days of initiation of PRP services?	*10.21.21.06 C*	There is no IRP in the record. The initial IRP was not completed within 30 days of the initiation of PRP services and there is no documentation in the record explaining why the IRP was not completed timely.	1. Per the COMAR regulations, the consumer should be officially referred to the PRP, undergo a screening assessment (or a comprehensive rehabilitation assessment is acceptable in place of the screening if it is completed within 10 days), receive a comprehensive rehabilitation assessment, and then staff can complete an initial IRP. Compliance with this item can be increased by completing the above steps in order. 2. Educate staff on the 30 day requirement for completion of initial IRP's.
11. Does the medical record document active participation in establishing the goals, objectives, and interventions of the IRP and is it documented that the consumer accepted or declined a copy of the plan?	*10.21.21.06 C (5)*	There is no IRP in the record or the consumer did not sign/date the IRP. The consumer signed/dated the IRP, but it is not documented that the consumer accepted or declined a copy of the plan.	1. Train staff that IRP's must be updated at a minimum of every 6 months for adults. 2. Ensure that all consumers are offered a copy of their IRP as well as their desire to receive a copy of the plan. Revise existing IRP template to include a section detailing consumer choice to receive an IRP copy.

13. Does the IRP contain goals, objectives or outcomes that are individualized, specific and measurable with an achievable timeframe?	*10.21.21.06 C (1)(b)(iv)* *CMS State Medicaid Manual Part 4 4221 C*	The goals are not individualized (i.e. "…will verbally discuss how she would like to be treated by others") or staff failed to address a time frame for goal achievement.	1. Train all staff on developing and writing individualized, specific, and measurable rehabilitation goals. Measurements include self report, client rating scales, observable outcomes, percentage to an established baseline, and counting events. The goals/objectives must also be individualized and not the same for each consumer.
15. Is a Rehabilitation Plan Review completed at a minimum of every 6 months?	*10.21.21.06 C (3)*	No IRP review(s) are present or IRP reviews have not been completed at a minimum of every 6 months.	1. Train staff to complete IRP reviews with adult consumers at a minimum of every 6 months. Document the date each IRP was developed.
21. Are the contact notes complete?	*10.21.21.06 D (1)* *CMS State Medicaid Manual Part 4 4221 D*	No contact notes contain all of the required elements or there are no contact notes in the record. Less than 75% of the progress/contact notes contain all of the listed items (see recommendations column) or progress/contact notes are missing some of the required items.	The contact note should include: • date • start time and either end time or duration of services (if not documented in a readily accessible billing document) • the consumer's chief medical complaint of reason for visit • delivery of services specified by the IRP description of services provided • location • legible signature with job title and/or mental health license. • The PRP claims data submitted must have a corresponding dated contact note as proof that the service occurred.
23. Do the monthly progress notes reflect the consumer's response to the interventions and their progress towards goals?	*10.21.21.06 D (2)* *CMS State Medicaid Manual Part 4 4221 D 7*	Progress notes fail to contain the consumer responses to interventions and their progress towards goals included in the IRP, but rather give information unrelated to the interventions listed on the IRP or there are no monthly progress notes in the record.	Either the contact note or monthly summary note must contain: • an assessment of the individual's progress toward goal achievement that incorporates the perspective of both the individual served and staff involved • changes in the individual's status • a summary of the rehabilitative services provided.

PRP-Minor

Also see comments under OMHC and Adult PRP headings related to:

- **Proof of legal guardianship via court orders, custody agreements**
- **Consumer choice to receive only off-site or only on-site PRP services**
- **Goal Measurability**
- **Transition/Discharge Planning**
- **Required signatures on plans**
- **Submission of Discharge Summaries**
- **Collaboration with the PCP**

Audit Item#/Description	Regulation/COMAR/CMS Citation	Area of Deficiency	Recommendation(s)
7. Was a face-to-face screening assessment completed within five (5) working days of the program's receipt of a PRP referral to determine rehabilitation needs and willingness to participate in PRP services?	*10.21.29.05 B(1)(a)(i)(ii)*	There is no screening assessment to determine appropriateness of PRP services or the assessment was not completed within five working days of the referral.	1. Train staff to complete face-to face screening assessments for minor consumers within 5 working days of a PRP referral. 2. Train staff to conduct a screening assessment to assess the minor's rehabilitation service needs and willingness to participate in PRP services.
9. Is there a comprehensive PRP Rehabilitation Assessment that was completed within 14 calendar days of initiation of PRP services?	*10.21.29.06 B* *CMS State Medicaid Manual Part 4 4221 B*	• There is no Rehabilitation Assessment in the record. • The Rehabilitation Assessment is not completed within the required timeframe. • The Rehabilitation Assessment is present, but missing some of the required elements of the MHA regulatory standards for assessments.	1. The assessment shall document at a minimum the minor's age and developmentally appropriate strengths, skills, and needs in the following areas: • Self care skills • Social, peer, family, and teacher interaction skills; • Participation in psychiatric treatment; • Semi-independent living skills; • Family support and resources; • Academic achievement; • Community and informal support systems; and

			• Adaptive equipment or resources; • As relevant, a review of the individual's legal status and forensic history, if any; • The minor's history of physical, abuse, sexual abuse, or substance abuse, if any.
11. Does the medical record document active participation in establishing the goals, objectives, and interventions of the IRP?	*10.21.29.06 C (1) (a) (i) (ii)* *10.21.29.06 C (4) (a) (i) (ii)*	The IRP does not have a complete signature from the consumer/parent/legal guardian demonstrating active participation in the rehabilitation planning process.	1. Train staff to develop the IRP in collaboration with the consumer/parent/legal guardian present and obtain signatures and dates on each IRP.
15. Is a Rehabilitation Plan Review completed at a minimum of every 3 months?	*10.21.29.06 C (3)*	No IRP review(s) are present or IRP reviews have not been completed at a minimum of every 3 months.	1. Train staff to complete IRP reviews with minor consumers at a minimum of every 3 months.