Documentation Review

Best Practices
Amy Barnett - Chesterfield County Public Schools

Utilization Review Requirements

General Requirements:

- Information that must be readily available to the Medicaid Agency:
  - IEP page(s) that document the services
  - Need for assessment documented in the IEP (PLAAFP or Considerations page)
  - Assessment findings must be captured in the service documentation of an IEP
- Plans of Care (POCs)
  - Medical/Treating diagnosis (refer providers to icd10data.com to find an appropriate code)
  - Type, amount and frequency of service
  - Measurable long-term goals (one year duration maximum)
  - Therapeutic interventions
  - POC goals must relate to services in the IEP
  - Signature, title and date of qualified provider completing the POC
- If the IEP serves as the POC, must include all of the above information

Utilization Review Requirements

General Requirements (cont.):

- Progress Notes
  - Each form must be initialed, signed and dated (signature must include at least the first initial, last name and title of provider and be dated with complete dates (month/day/year))
  - Each entry must be initialed by the provider of services
  - Care rendered under the supervision of a DMAS qualified provider must be signed off on by the qualified provider
  - Records must identify:
    - Student name and Medicaid/FAMIS number on each page
    - Progress/Response to treatment
    - Any change in diagnosis or treatment
- Record Retention - must be maintained for a minimum of 6 years following the last student encounter

Utilization Review Requirements

OT/PT/SLP/Audiology:

- Evaluations (to include diagnosis/treatment code, findings, current status, previous therapy)
- Evaluation Request
- Plan of Care (to include long-term goals, interventions/treatment/modalities, discharge goal, provider signature)
- Progress notes (to include response to treatment and provider signature)
- IEP Progress Reports
- Discharge summary (if applicable) (to include reason for discharge, functional status at discharge compared to admission, status of goals met or not met, recommendations for follow-up care, and provider signature)

Utilization Review Requirements

Psychiatry, Psychology, and Mental Health:

- OT/PT/SLP requirements AND
- History (to include onset of diagnosis, family dynamics, situational considerations, previous treatment and outcomes, medications, medical history, treatment from other programs, functional limitations, plans of treatment, results of DIE, diagnosis within the last year)
- Notes (to include how activities relate to goals, length of the session, student participation in treatment, modalities of treatment, progress, plan for next session, evidence of discharge planning, signatures)

Utilization Review Requirements

Psychiatry, Psychology, and Mental Health (cont.):

- Treatment should be based on:
  - DIE
  - Psychological Testing
  - Therapy Progress Notes
- Documentation must include
  - Focus of treatment related to diagnosis
  - Student-specific goals related to symptoms/behavior
  - Estimated length that treatment will be needed
  - Frequency/duration of the treatments
  - Documentation of family/caregiver participations as applicable
  - Signature and date on plan of treatment

Utilization Review Requirements

Audiology:

- OT/PT/SLP requirements AND
- Assessment/Evaluation reports
- Plan of Care (to include measurable goals, level of improvement anticipated, time frames for improvement/goal achievement, therapeutic interventions, identification of a discharge plan)
- Progress notes
- Discharge summary if applicable

Utilization Review Requirements

Nursing:

- Nursing POC (to include date of implementation, medical condition/ICD 10 code, goals and objectives, medication/treatment/procedures, dose and frequency of services, provider of services)
- Nursing Service Student Log (to include student name and DOB, Medicaid or FAMIS number, date, time of day and amount of time for service, procedure rendered, response to treatment [normal or varient], actions related to nursing services, nurse signature, supervision notes if appropriate)
- Prescribed drugs as part of the POC (to include quantities, dosage and frequency)
- Any changes to physician written order

Utilization Review Requirements

Personal Care:

- Plan of Care (to include student name and DOB, date of implementation, medical condition and ICD 10 code, goals and objectives, interventions/procedures, supervisor signature/date)
- Personal Care Service Logs (to include date/time of day/amount of time, procedures performed, student response to procedure [normal or variant], initials of person rendering service, signature of Personal Care assistant and supervisor, documentation of supervisory visits)

Utilization Review Requirements

Transportation:

- Indication of specialized transportation needs in the IEP
- Trip Log (to include students on the bus, dates of service, number of one-way trips)
- DMAS covered service received and billed on the day of transportation services
- Observation of student's arrival/departure on the bus
- Signatures of driver/bus attendant and medicaid coordinator/billing staff

Utilization Review Requirements

What DMAS is looking for: (Includes but is not limited to)

- Comprehensive care being provided
- Adequacy of services to meet needs and promote maximum well-being of each student
- Necessity and desirability of continued services
- Documentation of services in the IEP to support medical necessity and authorization for services
- Verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations

Reimbursement Requirements

- DMAS qualified provider must be part of IEP team (except for nursing and transportation)
- Medicaid/FAMIS requirements are followed as defined in Chapter IV
- POC completed and signed by qualified provider
- Services provided by a qualified provider
- Services address the identified goals
- Services are expected to improve, maintain or at a minimum slow progressions
- Progress should be made in a reasonable amount of time
- Documentation must be available for services rendered and/or reimbursed
- Renewal of the IEP and POC must be completed at least once per school year

How can you review this information?

How can you review documentation?

MAKE SURE YOU KNOW HOW TO FIND ALL THE AUDIT INFORMATION.

- Check with Special Education Administration to make sure you have access to the IEP documentation
  - Evaluation Report uploads
  - Present Levels (nursing/personal care statements, evaluation information)
  - Service pages (OT/PT/SLP/Audiology/Psych services)
  - Special Transportation pages
  - Progress Reports
- Coordinate with department leads to ensure that paperwork used for Medicaid documentation is being completed correctly
  - OT/PT/SLP/Psychology/Nursing
  - Building-Level Special Education Administration

How can you review documentation?

MAKE SURE YOU KNOW HOW TO FIND ALL THE AUDIT INFORMATION.

- Know where providers are keeping documentation
  - Plans of Care
  - DMAS Progress Notes
    - These should be in your possession if you are seeking reimbursement manually through the portal
  - Access to vendor's documentation records if you use a vendor

What we do in CCPS

Nursing

- Documentation is maintained on paper
- POCs are initially reviewed by Medicaid team to ensure diagnostic codes, goals, treatments, dates align with expectations
- POCs are then reviewed by nursing supervisors to ensure that discipline specific information is correct
- All nursing documentation is reviewed by Medicaid team as it comes in to make sure that it meets basic DMAS requirements (signatures, dates, etc.)
- Communication with Nursing department on standards of practice (quality of documentation)

Personal Care

- Documentation is maintained on paper
- As with nursing, POCs go through a two-step review process
- All documentation is reviewed by Medicaid team to make sure that basic requirements are met
- Communication with Nursing department on quality of documentation by aides/clinic assistants

What we do in CCPS

OT/PT/SLP

- Documentation is kept online through a vendor
- Quality maintenance reviews
- Get the staff involved to review the information
- Have go-to providers (I am a licensed SLP) to help with reviews
- Guidance needs to come from someone in their discipline

Psychology

- Documentation is kept online through a vendor
- Only evaluations are submitted for reimbursement
- Check to make sure that all available evaluations are submitted/documented
- Assist with guidance as needed (help from someone in discipline)

What we do in CCPS

Monitoring Reports - every month the Medicaid team uses tools/reports from our vendor to check for basic documentation requirements. This does NOT look at the quality of the documentation, only the basic documentation requirements. We then take this information and share with department supervisors monthly.

- Compliance percentages - are IEP minutes being met?
- Past Due Services
- Missing e-signatures
- Caseload comparisons - are all students with an IEP being documented on?
- Service details
  - Strange or unexpected ICD 10 codes
  - Delivery statuses that don't align with CCPS practices (ex: student testing)
  - Evaluations being captured

How can you review documentation?

GET STAFF INVOLVED WITH QUALITY MAINTENANCE!
They are the experts in their own discipline to determine adequacy of services and documentation of services!

- Gather all of the required pieces of documentation
- Black-out identifying information
- Have providers review the documents
  - Staff Meetings
  - Voluntary Reviews

Guiding Questions

IEP

- Does the present level of the IEP fully describe the strengths and weaknesses of the student?
- Are the services listed in the IEP well described in the LRE?
- Can you discern what the therapists target skills (goals/objectives) are?

Guiding Questions

POC

- Does the POC accurately reflect what is in the IEP?
- Is the diagnostic code appropriate?
- Does the functional deficit section include areas of strengths and weaknesses?
- Is there measurable data in the summary of previous treatment of the POC?
- Do the goals reflect the therapist's discipline?
- Are the interventions/treatments/modalities appropriate?

Guiding Questions

Notes

- Is the diagnostic code appropriate?
- Are the progress notes measurable?
- Do the notes use language that is understandable to a non-therapist?
- Can you see progress in therapy?
- Do all of the documents align?

Questions?

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