Spring 2010 Targeted Case Management (TCM) File Reviews

The purpose of on-site Targeted Case Management file reviews is to monitor the file documentation for compliance with Medicaid requirements. The reviews also serve to verify the high quality work Service Facilitators are doing. During the first week of March, 51 files from 3 different agencies-KAFASI, Prevention Services Network (PSN) and Professional Services Group (PSG) were reviewed. The files, most having numerous claims, represented a random sampling from most Service Facilitators.

For the overwhelming majority of claims, there was outstanding documentation, meaning there were comprehensive assessments, signed and dated Plans of Care, and ongoing notes documenting case management activities which were linked to the Plan of Care.

For the 2009 calendar year, there were only three clients whose Medicaid revenues were returned as a result of our file review. One was for a client who was staying with someone who was not a parent or legal guardian and the other two had addition errors in counting the case management time. A net total of $970.02 was recouped to Wisconsin Medicaid.

There also were items found that need to be improved. Please review this list:

1. A Case Manager's credentials should be identified.

2. The original and all updates to the Plan of Care must be signed and dated and the signature and date should be next to each other.

3. The following are not Medicaid billable under Targeted Case Management: leaving a message, leaving a voicemail, traveling to a client's home and finding no one at home, no shows, and attempted contacts.

4. In the ongoing phase, Wisconsin law includes "Case specific staffing and meetings with unit supervisors are in the definition of collateral contacts when the recipients issues are discussed." Note that conversations (even if case-specific) with co-workers other than unit supervisors are not billable to Medicaid.

5. The child must not be out-of home. The child must live with their parents or legal guardians to be billed to Medicaid for Targeted Case Management.

6. "Wisconsin Medicaid covers case management (Institutional discharge planning) for up to 30 days prior to discharge"…provided it does not " duplicate discharge planning services that the institution is expected to provide as a part of inpatient services." The only MA billable services allowed during hospitalizations should be limited to non duplicated discharge planning services.

*7. Use only commonly known abbreviations.*

8. Any cross out or white-out of notes should be initialed and dated or signed and dated by the individual crossing out the information.

Please note and use the above reminders to continue improving your documentation which warrants the Medicaid billing. Thank you for continued efforts.

Checklist Manifesto

"Good checklists… are precise. They are efficient, to the point, and easy to use even in the most difficult situations. They do not try to spell out everything…Instead, they provide reminders of only the most critical and important steps- the ones that even the highly skilled professionals using them could miss. Good checklists are, above all, practical."
Gawande, A. The Checklist Manifesto, 2009

In reviewing files, it seems the best documentation results are produced by those using checklists. There is a fascinating book called The Checklist Manifesto, written by a surgeon, Dr. Atul Gawande, who had great success in using checklists for ensuring that the right things are done at the right time. The theory being that the checklist frees the individual up to do consistent, quality work and helps in reducing complexity. Thus you see the widespread use of checklists in aviation
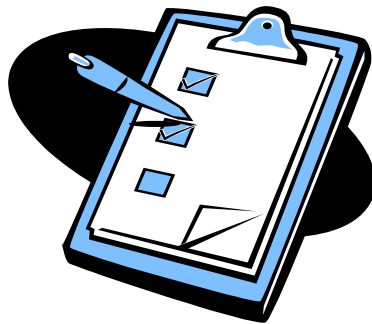
to ensure that everything is done and is checked before the plane leaves the ground and that vital checks aren't overlooked or forgotten-i.e. the preflight checklist. The book authors found similar quality improvements also from using checklist in the medical/surgical setting.

There is a parallel to Medicaid documentation where there are numerous forms and signatures and procedures to be followed. Lisa Haen, Director of the Community Support Program (CSP) at KHDS, uses checklists at the beginning of every file as a reminder for Service Facilitators. The checklists "are useful for so many things", she said. The one page checklist serves as a great reminder "of what you need to get done".

In the course of a busy week or month, it is easy to overlook developing and signing a six month Plan of Care update, or an annual functional screen, but a checklist can help keep you on target. Haen notes she has used checklists since college.

Checklists are designed to be brief, useful, cover important tasks and are meant to be constantly tweaked and updated in order to increase their effectiveness.

Attached are examples of One page checklists for CSP/CCS and TCM clients. Customize your own. Make it brief, and improve it regularly.

CSP Medical Record
File Review Checklist

Client Name _____ MA # _____

Reviewer Name _____ Date _____

Service Facilitator: _____

Please review other materials to determine the specifics needed for each item:

1. Consumer name, MA ID number, and other .... Yes   No
   basic demographic information

2. Dated and Completed Functional Screen .... Yes   No
   (Determination of Need for CSP)

3. Dated and Completed and signed Assessment .... Yes   No

4. Dated Psychiatrist signature on Treatment Plan .... Yes   No

5. Dated Clinical Coordinator signature on .... Yes   No
   Recovery/Service Plan

6. Dated and signed Recovery/Service Plan Updates ...... Yes   No   N/A
   at least every 6 months

7. Dated and signed progress notes for each .... Yes   No
   service unit(s) delivered on each day
       a. CSP staff member initials and credentials/position

Community Support Program
File Checklist

❑   Face Sheet

         o   HSRS Mental Health Module

❑   Intake Forms

         o   Referral Form

         o   Informed Consent

         o   Program Orientation

         o   Consumer Rights, Grievance Procedure & Right of Access to Courts

         o   Health Information Privacy Notice

         o   Medication Consents

❑   Consent Forms

         o   Release and Exchange of Information

         o   Photography Consent

❑   Assessments

         o   Initial Assessment & Recovery Plan

         o   Nursing Health Assessment

         o   Alcohol & Drug Assessment

         o   In-Depth Assessment

         o   Suicide Assessment

         o   MH & AODA Functional Screen

❑   Treatment Plans

❑   Recovery Plan

         o   Wellness Recovery Action Plan - WRAP

❑   Medication Profile

❑   Labs

❑   Doctors NotesAnnual Diagnosis

❑   Progress Notes

❑   Miscellaneous

Targeted Case Management
File Checklist

Is the child living with parent(s) or legal guardian(s)?   **Yes   No**

     If No, do not bill Medicaid (except for B-3)

For those Assessment elements that do not apply to this client, is N/A marked? Yes   No

Does the Plan of Care(POC) list Problems/issues identified during the assessment-Yes No

Is the Plan of Care signed and dated by the Service Facilitator   Yes   No

Is the POC reviewed/ updated every six months and signed and dated   Yes   No

Each case note ties back to a goal or goals in the plan of care   Yes   No

If applicable, there is rationale for a substitute case manager in case notes   Yes   No

Name of recipient found on each page of case notes   Yes   No

There is a written signed progress note for all Medicaid billing   Yes   No

CCS Medical Record
A Quick Review

Client Name:_____

1.   Consumer name, MA ID number, and other basic .... Yes   No
        demographic information

2.   Dated CCS Application .... Yes   No

3.   Dated and Completed Functional Screen .... Yes   No
        (Determination of Need for CCS) Including presenting
        problem

4.   Dated and Completed Assessment....................................... Yes   No

5.   Dated MD prescription (must be renewed annually) .... Yes   No

6.   Dated and signed Recovery/Service Plan............................. Yes   No

7.   Dates and signed Service Plan Updates......................Yes ... No   N/A

8.   Dated and signed progress notes for each service unit(s) ..... Yes   No
        delivered on each day

        a.   CCS staff member initials and credentials/position
        b.   Progress note must address the specific goals and
                objectives in the recovery/service plan
        c.   Progress note should reflect progress towards
                objectives in the recovery/service plan.

9.   Medical charge log identifying each service and.................... Yes   No
        service unit(s)for each day of service delivery. Initials and
        credentials of the service facilitator must be on each page
        or electronic entry.

10.   Signature of Mental Health Professional on Recovery .... Yes   No
        Plan authorizing every service to be delivered, at initial
        onset as well services as ongoing when new are introduced.

Be creative in making up similar checklists for your area. Remember to make them brief but be sure to include the essential ingredients for quality. In the case of CCS, there are 10 items on the checklist but they are the important elements of documentation. If we see this checklist on the files and being used, it is a good bet that the file itself will be up to date and compliant with regulations.