

Instructions for FY 08-09 Record Audit Tool Child Service Coordination Program

Instructions: Per the FY 08-09 CSCP Agreement Addendum, all agencies providing CSCP services will have a quality assurance plan on file which outlines all monitoring activities related to Child Service Coordination services:

IV. 2. It is the responsibility of the Health Department to monitor local CSCP records for quality assurance and appropriate documentation. The Health Department will ensure this service deliverable by conducting a program record review using the FY 08-09 DPH CSCP Audit Tool and accompanying Instructions Document. NC Administrative Code 10A NCAC 46 .0203 requires local health departments to conduct a program assessment, including record review at least once a year. Because child service coordinators work independently, local health departments are required to conduct semi-annual record reviews. Selection of random records must be made by a staff member who is not involved in providing direct CSCP services. The selection will include one non-Medicaid file and at least five randomly selected records from a list of recent billings submitted to Medicaid such as HSIS Report 154D (Medicaid Claims Processed). If more than one staff person is providing CSCP services, at least one record should be reviewed for all staff providing services since the last audit period. If deliverables are not being met or performance falls below expectations, notify the CSCP manager. The manager or the appointed designee will work with appropriate staff at the local health department to develop a corrective action plan.

IV. 4. All agencies providing CSCP services will have a quality assurance plan on file which outlines all monitoring activities related to CSCP services.

General Instructions

- Indicate with a check (√), Zero (0), or NA whether an item is present, not present, or not applicable.
- If a clinical standard has multiple components, all components must be met/present for the standard to have been met.
- For items with more than one component, "Record Compliant" may be checked if all the boxes above the Record Compliant line have either checks or NA's in them. If any box has a Zero (0) in it, then Zero (0) must appear in the Record Compliant line for that record for that standard. See example below:

13. Transition to another CSCP agency	1	2	3	4	5
a. Update of care coordination plan	√	√	√	√	√
b. Collaboration between old & new CSC	√	√	0	√	√
c. Notification of care giver	√	√	√	√	√
d. Submission of SR, if applicable	NA	√	√	NA	√
e. Documentation of the transition	√	√	√	√	√
Record Compliant?	√	√	0	√	√

For the above item, Record #3 was not compliant because one of the required components for the item was not completed.

Scoring

- All items should have 100% compliance.
- There is no formal scoring process.
- Items that are not compliant require an action plan to address findings.

Instructions for FY 08-09 Record Audit Tool Child Service Coordination Program

Applicable sections from the Division of Medical Assistance Child Service Coordination Clinical Coverage Policy are referenced in this document. This Policy can be accessed at: <http://www.dhhs.state.nc.us/dma/babylovechild/1m1.pdf>. Also, applicable sections from the Basic Medicaid Billing Guide (April 2008) are referenced when applicable. This guide can be accessed at <http://www.dhhs.state.nc.us/dma/medbillcaguide.htm>.

The Audit Tool is divided into two sections:

- A. Requirements of the Division of Medical Assistance (DMA) and the Division of Public Health (DPH) to determine medical necessity and verify services were billed correctly, and
- B. Requirements of DPH to determine that all program requirements outlined in the DMA CSCP Clinical Coverage have been met and documented.

Section A is used to determine that the record contains documentation to justify payment of services by DMA. Both Sections A and B will be used by DPH as part of the Children and Youth Branch Program Reviews. Agencies are instructed to use both Sections A and B as part of the agency's required Quality Assurance Plan activities.

Section A: 1. Service Documented

Basic Medicaid Billing Guide (April 2008) pages 3-3 and 3-4

Medicaid providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program as a condition of participation. For each contact billed, the record must contain:

- a. Type of Contact: How was the family contacted, i.e. face-to-face or phone call?
- b. Purpose of contact: Why did the provider contact the family?
- c. Provider intervention: What services were provided to the family during the visit? This information may be found on the care plan or in the narrative notes.

Section A: 2. Diagnosis Code

Basic Medicaid Billing Guide (April 2008) pages 3-3 and 3-4

DMA CSCP Clinical Coverage Policy Section 5.4

- a. Is the diagnosis code one that supports medical necessity? In other words, is there any documentation in the record supporting the risk conditions on the Identification and Referral (I & R) form (DHHS 3748)? The CSCP record must contain documentation indicating that the referring risk conditions have been substantiated based on the **Glossary of Risk Indicators from the NC Child Service Coordination Program**, updated July 2002. This documentation could consist of official hospital records, statements made by the parent, observations made by the CSC, etc. Completion of the front side of the recommended NC Child Service Coordination Program Risk Indicator Form (DHHS T1516) could meet this program requirement. At least one risk condition must be substantiated in order for CSCP enrollment to occur. This item would be *NON-APPLICABLE* if all the referring risk conditions were determined to be unsubstantiated, and therefore the child was not enrolled in CSCP. This item would also be *NON-APPLICABLE* if the family refused enrollment.
- b. If during the enrollment contact, the CSC identifies additional risk conditions, the additional risk conditions should be documented in the record along with the information used to substantiate the additional risk conditions. The CSCP record must contain documentation indicating that the additional risk conditions identified during enrollment have been substantiated based on the **Glossary of Risk Indicators from the NC Child Service Coordination Program**, updated July 2002. Completion of the front side of the recommended NC Child Service Coordination Program Risk Indicator Form (DHHS T1516) could meet this program requirement. This item would be considered *NON-APPLICABLE* if there is no indication in the record that additional risk conditions should have been identified during enrollment.

Instructions for FY 08-09 Record Audit Tool

Child Service Coordination Program

Section A: 3. Identification and Referral Form

DMA CSCP Clinical Coverage Policy Section 5.1

All children enrolled will have a completed Identification and Referral form (DHHS 3748). The I & R form must be found in the CSCP record, and the following items on the I & R form must be completed for this item to be considered *PRESENT*:

- Items #1 through #11
- Item #12 – must at least contain name of referral source
- Item #13 – must at least contain name and address of parent
- Item #15 – must have at least one risk condition circled

Items #16 and #17 are not mandatory, although the information could be helpful.

Section A: 4. Signed Letter of Agreement

DMA CSCP Clinical Coverage Policy Section 5.6

All children enrolled in CSCP will have a completed and signed Letter of Agreement between the designated Child Service Coordinator and family. There must be a signed Letter of Agreement in the CSCP Record when:

- a. A child is initially enrolled in CSCP. This item would be considered *NON-APPLICABLE* if the family is offered enrollment, refused enrollment, and is closed to the CSC Program
- b. A new CSC from the same agency has been designated the Child Service Coordinator for the family during the time period being reviewed. If the original CSC is not available for an extended period of time (three months) a new Letter of Agreement is required. This item would be considered *NON-APPLICABLE* if there was not been a change in CSCs.

Section A: 5. Family and Child Strengths/Needs Assessment

Basic Medicaid Billing Guide (April 2008) page 3-3 and 3-4

DMA CSCP Clinical Coverage Policy Section 5.7

The reviewer must assess:

- a. **Frequency:** A Family and Child Strengths/Needs Assessment must be completed upon enrollment and at least every 6 months thereafter. This item would be considered *NON-APPLICABLE* if the family refused enrollment or did not receive services and the agency did not receive reimbursement for services for 6 consecutive months during the time period being reviewed. This item will be considered *PRESENT* if there is documentation that the assessment was attempted, the reason the assessment could not be completed, i.e. family did not have time to complete assessment, etc., and the assessment was completed at the next possible opportunity. According the Question #4 in Chapter 3 of the CSCP Questions and Answers document (May 2008), the ... "Strengths and Needs Assessment must be completed face-to-face."
- b. **Quality:** The reviewer must be able to tell whether or not an item was "not applicable" or simply "skipped over". There must be some indication that the majority of the required elements are assessed. The use of codes, such as O = No Problems, is one way to indicate that an element has been assessed. If a problem or need has been identified, then there must be a description of the identified problem or need. This item will be considered *PRESENT* if the recommended DMA 3006 form (Rev 5/00) or a locally developed assessment form that contains all the required components of the DMA 3006 is completed.

Section A: 6. Care Coordination Plan

Basic Medicaid Billing Guide (April 2008) page 3-3 and 3-4

DMA CSCP Clinical Coverage Policy Section 5.12

The reviewer must assess:

- a. **Frequency:** The Care Coordination Plan must be initiated upon enrollment. In addition, the Care Coordination Plan must be reviewed and updated at least every 3 months. This item would be considered *NON-APPLICABLE* if the family refused enrollment or did not receive services for 3 consecutive months during the time period being reviewed.

Instructions for FY 08-09 Record Audit Tool Child Service Coordination Program

- b. **Quality:** Although the CSC can choose the format of the Care Coordination Plan (i.e., SOAP notes, DMA 3007, etc.), the Care Coordination Plan must include:
1. Goals and activities written in clear behavioral terms
 2. Goals and/or activities to address identified Risk Conditions, when possible
 3. Goals and/ or activities to address needs identified through the Family and Child Strengths/Needs assessment and/or the Parent-Child Interaction Assessment
 4. Parties responsible for completion of each activity, such as CSC, family, etc.
 5. Timelines for accomplishment/reassessment
 6. Assessment of progress: Is the previously developed plan working? This information may be found on the care plan or in the narrative notes.
- The recommended DMA 3007 form could be used to meet this program requirement.

Section A: 7. Billing Guidelines

Basic Medicaid Billing Guide (April 2008) pages 3-3 and 3.4 DMA CSCP Clinical Coverage Policy Section 8.0

The reviewer must assess:

- a. **Time service component:** Is the time of service documented in the record? Were the minutes of service correctly converted to units, based on 1 unit = 15 minutes with no proration or rounding up?
- b. **Documentation justifies units billed:** Is there documentation to support the number of units billed? Was the number of units appropriate for the level of service provided? For example, if 4 were paid for a telephone contact where very little information was documented from the phone call and no other services were documented, the auditor may determine that the level of service did not justify the number of units billed.
- c. **Units documented match units billed:** Do the units documented in the record match the number of units billed/paid. This information can be verified by administrative support staff with access to HSIS Screen 68 or HIS.

Section B: 1. Initial Follow-Up of the Referral: non-health department agencies ONLY

DMA CSCP Clinical Coverage Policy Section 5.3

An agency should have documentation that the local health department has been contacted for verification of a child's enrollment status. This item would be *NON-APPLICABLE* for health department provider agencies. See Section 5.3 of DMA CSCP Clinical Coverage Policy.

Section B: 2. Enrollment

DMA CSCP Clinical Coverage Policy Section 5.4

- a. There must be documentation that contact was attempted within 2 weeks of being received by the CSCP agency (item #14 on I & R Form). This item would be considered *NON-APPLICABLE* if there is documentation indicating the child was promptly placed on a waiting list when attempted contact within 2 weeks was not possible. See also Section 5.18 DMA CSCP Clinical Coverage Policy
- b. All new referrals who are possibly eligible for the I-TP must be contacted within 2 working days (see 4/26/06 Early Intervention Memo regarding new I-TP eligibility criteria). This item is only applicable when a child who possibly meets I-TP eligibility criteria has an initial contact with a CSC for the purpose of I-TP enrollment. In the case where a referral for a child who is possibly eligible for the I-TP is sent directly to the I-TP (or CDSA), and therefore the family was not contacted by the CSC, this item would be *NON-APPLICABLE*.

Instructions for FY 08-09 Record Audit Tool Child Service Coordination Program

- c. If risk conditions are unsubstantiated, the reason for the unsubstantiation should be documented in the record. Completion of the front side of the recommended NC Child Service Coordination Program Risk Indicator Form (DHHS &1516) could meet this program requirement. The risk condition could also be marked through on the I & R form, initialed and dated. The CSC's documentation for that date would support the risk Conditions being unsubstantiated. This item will be considered *NON-APPLICABLE* if there is no indication in the record that a referring risk condition should be unsubstantiated.

Section B: 3. Developmental Follow-Up/Intermediate Assessment Process

DMA CSCP Clinical Coverage Policy Section 5.9

According to the DMA August 2005 Medicaid Bulletin, an Intermediate Assessment is no longer a program requirement as of August 1, 2005.

Section B: 4. Preventive Health Service (PHS)

DMA CSCP Clinical Coverage Policy Section 5.11

Informing families of the importance of preventive health care and assisting them in accessing these services is a CSC Program requirement. There is a difference between assessing for Preventive Health Services and informing families of and assisting families with Preventive Health Services, although these actions can be interrelated. PHS should at least be addressed close to the following ages of the Health Check Periodicity schedule, which is: Newborn, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, and 5 years. The CSC should not schedule a contact with the family just to address PHS, but should incorporate PHS into contact with families. Families should be informed of PHS based on their need and their ability to absorb the information. It may be too much to cover all aspects of PHS in one visit. Preventive Health Services **may include, but are not limited to:**

- a. Well Child Care: In order for the CSC to inform the families on the importance of well child care and assist them in accessing well child care services, the CSC must know the current status of well child care, which should be documented in the CSCP Record.
- b. Nutrition: In order for the CSC to inform families on the importance of nutrition and assist them in accessing nutritional services, the CSC must assess and document the family's eligibility, interest and/or participation in WIC services.
- c. Safety
- d. Dental Health
- e. Development
- f. Child Care
- g. Immunizations: In order for the CSC to inform the families on the importance of immunizations and assist them in accessing immunization services, the CSC must know the current immunization status, which should be documented in the CSCP Record.
- h. Other

The reviewer will use documentation of the individual child's needs as well as general knowledge of child health to determine which preventive health services would be applicable for each individual child. This item will be considered *PRESENT* if families are informed of the importance of all appropriate preventive health services and assisted in accessing these services. Documentation that families were informed of and assisted with accessing Preventive Health Services may be found in different sections of the chart, such as the Family and Child Strengths/Needs Assessment, the Care Coordination Plan, the Notes, etc. Completion of the recommended NC Child Service Coordination Program Preventive Health Services Form (DHHS T1518) could be used to meet this program requirement. This item will be considered *ABSENT* if all preventive health services determined to be applicable are not addressed during the time period being reviewed.

Instructions for FY 08-09 Record Audit Tool Child Service Coordination Program

Section B: 5. Level and Frequency of Contacts

DMA CSCP Clinical Coverage Policy Section 5.13

This item will be considered *PRESENT* when the reviewer deems the level and frequency of contacts appropriate based on:

- a. family concerns and the activities outlined in the Care Coordination Plan
- b. number and complexity of the priorities and concerns
- c. availability of services within the area
- d. family's ability to address its concerns and use available support systems.

Section B: 6. Satisfaction with Service Provider(s)

DMA CSCP Clinical Coverage Policy Section 5.13

The CSC must discuss and document the family satisfaction with service provider(s) at least every 3 months. "Service Provider" is any one who is providing a service to the child/family. This item would be considered *NON-APPLICABLE* if the child received CSCP services for less than 3 months during the time period being reviewed.

Section B: 7. Update the Risk Indicators on the I & R form

DMA CSCP Clinical Coverage Policy Section 5.13

The CSC must:

- a. **Risk Indicators Reviewed & Updated:** There must be documentation that the CSC reviewed the current Risk Indicators on the I & R form at least every 6 months. This program requirement could be met by completion of the back of the recommended NC Child Service Coordination Risk Indicator Form (T1516). If during the review of Risk Conditions, the CSC identifies additional Risk Conditions, the CSC must document that the Risk Conditions have been substantiated based on the **Glossary of Risk Indicators from the NC Child Service Coordination Program**, updated July 2002. This item will be considered *PRESENT* if there is documentation of the Review of Risk Indicators at least every 6 months and that any appropriate additional Risk Conditions have been properly identified.
- b. **Referrals Made, If Appropriate:** When reviewing Risk Conditions, the CSC must determine whether the Risk Conditions indicate the child could possibly be eligible for other services, such as the Infant-Toddler Program or Preschool Services, and make appropriate referrals if indicated. This program requirement could be met by completing the back of the recommended NC Child Service Coordination Program Risk Indicator Form (T1516). This item will be considered *NON-APPLICABLE* if there is no indication that the child is possibly eligible for other services, such as the Infant-Toddler Program or Preschool Services.

Section B: 8. Assessment of Parent-Child Interaction

DMA CSCP Clinical Coverage Policy Section 5.8

The reviewer must assess

- a. **Frequency:** A Parent-Child Interaction assessment must be completed upon enrollment and at least every 6 months thereafter. This item would be considered *NON-APPLICABLE* if the family refused enrollment or did not receive services and the agency did not receive reimbursement for services for 6 consecutive months during the time period being reviewed. This item will be considered *PRESENT* if there is documentation that the assessment was attempted, the reason the assessment could not be completed, i.e. child was asleep, etc., and the assessment was completed at the next possible opportunity.

Instructions for FY 08-09 Record Audit Tool Child Service Coordination Program

- b. **Quality:** The documentation of the assessment of the Parent-Child Interaction must include:
1. Observed behaviors documented in objective statements noting a two-way interaction between the child and the caregiver; a judgmental or summary statement, such as "good interaction" would NOT meet this requirement
 2. Reinforcement of parent's strengths
 3. Developmentally appropriate activities shared with the caregiver
 4. Community Referrals offered, if appropriate

This program requirement could be met by completing the recommended NC Child Service Coordination Program Parent-Child Interaction Assessment Form (T1517 A-L).

Section B: 9. Transition

DMA CSCP Clinical Coverage Policy Section 5.14

Occasionally CSCP services may be transferred to another CSC within the same agency, or to another CSCP Provider agency in the same county. When, this occurs, the following should be documented:

- a. Update of care coordination plan
- b. Collaboration between old and new coordinator; if this is not possible, the reason should be documented
- c. Notification of care givers
- d. Submission of Program Status Report if transfer is to another CSCP Provider agency in the same county; this is not necessary if transition is within the same agency
- e. Documentation of that transition occurred

This program requirement could be met by completion of Section B on the recommended NC Child Service Coordination Program Closure / Transfer Form (T1519). This item would be *NON-APPLICABLE* if the child is not transitioned during the time period being reviewed.

Section B: 10. Closure

DMA CSCP Clinical Coverage Policy Section 5.16

When a child is closed to CSCP services, the following tasks must be completed and documented:

- a. Update care coordination plan with current status of each identified need/goal and future plans for unresolved needs/goals
- b. Document the reason for closure
- c. Contact the new CSC to review the file and share information, if applicable
- d. Notify appropriate caregivers
- e. Complete the Program Status form, indicating the reason for closure
- f. Facilitate a new Letter of Agreement, if applicable
- g. Inform family that CSCP can be reopened, if the requirements are met
- h. Notify the Health Check outreach worker

This program requirement could be met by completion of Section A on the recommended NC Child Service Coordination Program Closure / Transfer Form (T1519). This item would be *NON-APPLICABLE* if the closure was not planned, such as when the reason for closure is "Lost to Follow Up" or "Child Expired." This item would be *NON-APPLICABLE* if the child is not transitioned during the time period being reviewed.

Section B: 11. Status Report Requirements

DMA CSCP Clinical Coverage Policy Section 7.2

This item will be considered *PRESENT* if a completed status report (DHHS 3750) is per instructions on the form for the time period being reviewed. This item would be considered *NON-APPLICABLE* if, per the instructions on the form, completion of the Status Report would not be required during the time period being reviewed.