FAX

To: **Trish Stith**
Company:
Fax: 5028995411
Phone:

From:
Fax:
Phone: Fox, Lucy
E-mail: lucy.fox@beaconhs.com

NOTES:

Transformations, LLC Request for Site Visit 2015

Date and time of transmission: Monday, June 15, 2015 1:20:04 PM
Number of pages including this cover sheet: 04

PASSPORT HEALTH PLAN

Trish Stith
Transformations
4010 Dupont Circle
Louisville, KY 40207

June 11, 2015

Dear Provider,

You have been selected to receive a site visit for our 2015 Outpatient Behavioral Health Record Review process through Passport Health Plan. We would like to come to your site for approximately 4 hours and look at the outpatient charts of 12 Passport members. We will be utilizing a scoring tool, which we have enclosed for your review. We will send you the list of charts to be reviewed once you have set a date for the site visit.

Please contact Sarah Kremer, Clinician on the Outpatient Team, to arrange a mutually agreeable time for your site visit. You can reach her by phone at 502-552-5800, or email at Sarah.Kremer@beaconhs.com.

Sincerely,

Elizabeth W. McKune

Elizabeth W. McKune, Ed.D.
Director, Behavioral Health

PASSPORT HEALTH PLAN

Provider Name: _____ Member Name: _____

Provider ID: _____ DOB: _____ Member ID#: _____

Age at Intake: _____ LOB: _____

Question	Y	N	NA	Examples of Evidence	Qualifications
A. Documentation					
1. Is there documentation that the member received a copy of his or her rights?				Signed Receipt, Intake Packet, Note	If the rights are there but receipt not documented, score NO.
2. Are medication allergies & adverse reactions prominently noted in the record? If the member has no known allergies or adverse reactions, are these noted?				Assessment	Easily identified.
3. Is past medical history easily identified? If no significant medical history, is this noted?				Assessment, Progress Notes	
B. Continuity and Coordination – *Outpatient to Outpatient*					
1. Is there evidence in the chart that at least one Release of Information, Authorization, or Consent was obtained to speak with at least one other Outpatient [OP] mental health or OP substance abuse treatment provider?				Release of Information, Consent to Obtain Information	Six month look back. If there has not been OP treatment in past 6 months, score NA.
2. Is there evidence that the OP treatment provider **contacted, collaborated**, **received** clinical information from or **communicated** in any way with another OP provider regarding the member's clinical care?				Contact Note, Discharge Summary, Treatment Summary, Treatment Plan, Case Consultation Note, Progress Note, Evidence of Sent Release	Any documentation related to treatment from another BH provider, score YES regardless of response from other provider.
3. Is there evidence that the OP treatment provider **contacted, collaborated, received** clinical information from or **communicated** in any way with any state agencies or schools, community outlets, etc.?				Releases to other entities, DCF, Teachers, Mentors, Day Treatment, School, CBHI, CSP, DCF, DFPS, DADS	Clinical judgment. YES if any evidence in chart. NA if no evidence. This is not a required element.
C.* Continuity and Coordination – *PCP to Outpatient					
1. Is there evidence in the chart that a **Release of Information** was obtained to communicate with the PCP? (PCP must be identifiable)				Release of Information, Authorization to Release Information	If provider is a part of an integrated health system, score YES.
2. Is there evidence that the OP treatment provider **contacted, collaborated**, **received** clinical information from or **communicated** in any way with the PCP?				Contact Note, Discharge Summary, Treatment Plan, Case Consultation Note	Standardized PCP/BH form sent. Needs to be evidence of communication and when it was mailed/faxed, etc. Score YES if using an integrated medical record that can be seen by multiple providers within the system.
3. Is there evidence in the chart that a **standardized PCP/BH communication form** was used?				Any standard form exists in chart with BH info completed	Score YES if using an integrated medical record.
D. Comprehensiveness of Record (Age at Intake)					
1. Is there documentation that the member was screened for alcohol or other substance use? **(13 yo+)**				Assessment, Intake, Screening Section	Needs assessment, tool or some early progress note.
2. If the member screened positive for use, was this included in the diagnosis and/or treatment plan OR addressed on an on-going basis as part of treatment? **(13 yo+)**				Assessment/Intake, Screening Section, Treatment Plan, Progress Notes	Score NA if question 1 is NO. Screened positive = diagnosed with.
3. If the member screened positive for alcohol or other substance use was there family involvement in treatment? **(13 yo+)**				Progress Notes, Documented family therapy session, Family consultation, Mention of family involvement	Score NA if member refuses, not clinically indicated, or no identifiable support. Score NA if question 1 is NO.
4. If the member is age 13-18, was the member assessed for depression?				Assessment, Intake, Tool	
5. If the member is age 13-18 and screened positive for depression, was a suicide risk assessment conducted?				Assessment, Intake	Score NA if question 4 is NO. Screened positive = diagnosed with.
6. If the member is age 13-18 and screened positive for depression, was there family involvement in treatment?				Progress notes, Documented family therapy session, family consultation, mention of family involvement	Score NA if question 4 is NO. Screened positive = diagnosed with.
7. If the member is age 13-18 and screened positive for depression, is there evidence that he or she was referred to or participated in a medication evaluation for an antidepressant?				Progress notes, Indication of communication with or referral to a prescribing provider	Score YES If it is documented that psychopharm has been discussed & family has refused. Score NA if question 4 is NO. Screened positive = diagnosed with.
8. If the member is age 13-18 and screened positive for depression and was prescribed medication, is there evidence the OP provider is monitoring for medication(s) compliance?				Progress notes, Documentation of questioning patient about medication compliance	Score NA if question 4 is NO. Screened positive = diagnosed with.

9. If the member is age 6-12, was the member assessed for ADHD?				Assessment, Intake, Tool, Mental Status Exam	
10. If the member is age 6-12 and screened positive for ADHD, was there family involvement in treatment?				Progress notes, Documented family therapy session, family consultation, mention of family involvement	Score NA if question 9 is NO. Screened positive = diagnosed with.
11. If the member is age 6-12 and screened positive for ADHD, is there evidence that he or she was referred to or participated in a medication evaluation?				Progress notes, Assessment, Intake, Indication of communication with or referral to a prescribing provider	Score YES If it is documented that psychopharm has been discussed & family has refused. Score NA if question 9 is NO. Screened positive = diagnosed with.
E. Targeted Clinical Review					
1. Is the DSM or ICD **diagnosis consistent** with presenting problems, history, mental status exam and treatment plan?				Assessment, Treatment Plan, Mental Status Exam	Based on clinical judgment.
2. Does the treatment plan include objective and measurable goals?				Treatment Plan, Updates	Clinical judgment. YES if any evidence. NA if psych testing or meds only.
3. Does the treatment plan include short-term timeframes for goal/objective attainment or problem resolution?				Treatment Plan, Updates	Short term defined as 6 months or less.
4. Is the frequency of treatment greater than clinically indicated?				Treatment Plan, Progress Notes	Clinical judgment. Cancels or no-shows should not impact determination.
5. Are progress notes goal directed & focused on treatment objectives?				Progress Notes	Clinical judgment.
6. Is there any indication that provider is misrepresenting any services provided, i.e. patterns of duplicate billing?				Assessment, Treatment Plan, Progress Notes	Up-billing, Incorrect dates, etc.
7. Are there treatment notes to match the claims submitted?				Progress Notes	Score YES if claims have matching treatment notes, date of service matching within one day.
8. Is there evidence that an outcomes tool was used in determining the member's treatment plan?				Completed Outcomes Tool	Score YES if the chart contains a completed outcomes tool. NA if member refuses. Only YES or NA for non-MA plans (not mandatory).
9. Name of outcomes tool:					If YES on question 8, must specify tool used. List all tools used.
PHQ-9 Pilot Questions	**Y**	**N**	**NA**	**Examples of Evidence**	**Qualifications**
1. For members age 18 or older diagnosed with depression or dysthymia: Was the PHQ-9 tool used to **monitor progress** of treatment?				PHQ-9 Tool	YES: Tool was used more than once to monitor progress. NO: There is not evidence of the PHQ-9 being used to monitor progress. NA: The tool was used once and audit was performed before 4 months of treatment.
2. If question 1 was YES, was the tool used once every four months to monitor progress?				PHQ-9 Tool	

3. If question 1 was NA, select reason:

- ☐ Member not diagnosed with depression/dysthymia or the member was under the age of 18.
- ☐ The tool was used once, but the chart audit took place prior to the member's next appointment with the provider/physician.
- ☐ Other:

Comments: