CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 13537

Region: 05 Chicago

Contract Number / Name: H3614 TRIHEALTH SENIORLINK

Auditing Guide Version: PACE Audit Guide, Version 1

Auditing Element: SDY04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/18/2008

Date Report Due: 07/19/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 11/10/2008

MCO Response Due Date: 08/17/2008

Requirement:

The entire text is very lengthy and is not listed here in its entirety. See Regulation for entire text. (a) Initial comprehensive assessment" (1) Basic requirement. The interdisciplinary team must conduct an initial comprehensive assessment on each participant promptly following enrollment. (2) As part of the initial comprehensive assessment, each discipline of the IDT must evaluate the participant in person, at appropriate intervals, and develop a discipline-specific assessment of the participant's health and social status: (3) At the recommendation of team members, other professional disciplines (for example, dentistry, or audiology) may be included in the comprehensive assessment process. (4) The comprehensive assessment must include several areas such as physical and cognitive function and ability and medication use. (b) Development of plan of care. The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each participant through discussion in team meetings and consensus of the entire IDT. (c) Periodic reassessment" (1) Semiannual reassessment. On at least a semiannual basis, the following members of the IDT must conduct an in-person reassessment: Primary care physician, Registered nurse, Master"s-level social worker, Recreational therapist or activity coordinator. (2) Annual reassessment. On at least an annual basis, the following members of the interdisciplinary team must conduct an in-person reassessment: Physical therapist, Occupational therapist, Dietitian, Home care coordinator. (d) Unscheduled reassessments. In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following: (1) A change in participant status... (2) At the request of the participant or designated representative... (i) The PACE organization must have explicit procedures for timely resolution of requests by a participant or his or her designated representative to initiate, eliminate or continue a particular service... (iv) The PACE organization must explain any denial of a request to the participant or the participant's designated representative orally and in writing. The PACE organization must provide the specific reasons for the denial in understandable language. The PACE organization is responsible for the following: (A) Informing the participant or designated representative of his or her right to appeal the decision as specified in Sec.460.122. (B) Describing both the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services as specified in Sec.460.122. (C) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in Sec. 460.122(e). (v) If the IDT fails to provide the participant with timely notice of the resolution of the request or does not furnish the services required by the revised care plan, this failure constitutes an adverse decision, and the participant's request must be automatically processed by the PACE organization as an appeal in accordance with Sec.460.122. (d) Changes to plan of care. Team members who conduct a reassessment must meet the following requirements: (1) Reevaluate the participant's plan of care. (2) Discuss any changes in the plan with the IDT. (3) Obtain approval of the revised plan from the IDT and the participant (or designated representative). (4) Furnish any services included in the revised plan of care as a result of a reassessment to the participant as expeditiously as the participant's health condition requires. (e) Documentation. Interdisciplinary team members must document all assessment and reassessment information in the participant's medical record.

Deficiencies:

Reference: 42 CFR 460.210 (d) Medical Records Requirement: Maintenance of medical records. Authentication of medical records. All entries must be legible, clear, complete, and appropriately authenticated and dated. Status: Not Met Findings: Based on record review and interview, the Pace organization failed to maintain at least one medical record that was appropriately authenticated and dated. Examples: Write out, more commonly know as, ¿white out¿ was found in Ms. H's medical record on 8/25/06 and 9/27/08. Reported by: Wanda Hardges / Mary Davis Medical Records Status: Not Met Example: A member of the review team had a conversation with a participant¿s family member during the monitoring visit. The family member had indicated that they had a conversation with the physician regarding the participant health status. The family member had indicated that there was a change in the participant¿s health. This change was not documented in the case notes or on the medical record. The interdisplinary team should have been informed of this change in health status. Recommendation: The change in the participant¿s health status should have been documentation in the case notes to ensure that the ALL of the participant health and medical needs are being addressed. Follow- up: Tri Health is to give us an update on the status of the grievance that was filed while the monitoring visit was being conducted. (Participant¿s name is "F.F.")

Corrective Action Required:

Corrective Action Required: White out can not be used on a legal document. If a mistake is made, draw a single a line through the entry and write ¿mistaken entry¿ rather than error. ¿The word error could seem to indicate that a mistake in care was made.¿ (Documentation Legal Aspects On Aspects Online Nursing).¿ The writer person should draw a line through it, write their initials and delete the entry. Submit plan to educate staff regarding proper medical records documentation. Plan should include, but is not li not limited to training, development of internal quality control mechanisms, creation and / or update to policies and procedures and annual re-training as may be necessary. Notes/Recommendations: No write out can be use in a participant¿s medical record. All employees that document in the Pace organization should be in-service on Documentation Guidelines.

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Contract Number / Name: H3614 TRIHEALTH SENIORLINK

Auditing Guide Version: PACE Audit Guide, Version 1

Auditing Element: SDY05

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

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MCO Response Due Date: 08/17/2008

Requirement:

(a) Basic requirement. The interdisciplinary team must promptly develop a comprehensive plan of care for each participant. (b)Content of plan of care. The plan of care must meet the following requirements: (1) Specify the care needed to meet the participant"s medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment. (2)Identifiy measurable outcomes to be achieved. (c) Implementation of the plan of care. (1) The team must implement, coordinate, and monitor the plan of care whether the services are furnished by PACE employees or contractors. (2) The team must continuously monitor the participant"s health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from participants or caregivers, and communications among members of the interdisciplinary team and other providers. (d)Evaluation of plan of care. On at least a semi-annual basis, the inter-disciplinary team must revaluate the plan of care, including defined out-comes, and make changes as necessary.(e) Participant and caregiver involvement in plan of care. The team must develop, review, and reevaluate the plan of care in collaboration with the participant or caregiver, or both, to ensure that there is agreement with the pan of care and that the participant"s concerns are addressed.(f) Documentation. The team must document the plan of care, and any changes made to it, in the participant"s medical record.

Deficiencies:

Requirement: The team must continuously monitor the participant health and psychosocial status, as well as the effectiveness of the care plan through provision of services, informal observation, input from from participant or caregiver and communication among members of the interdisciplinary team and others. others. Status: Not Met Findings:: Based on record review and interview, the Pace or the organization medical record lacked documentation of a reassessment of Ms. H's blood pressure when her pressure her B/P was above 130/80. Examples: Ms. H's goal on her 10/07and 6/08 care plan states her blood pressure should be 130/80. Here is Ms. H's vital sign flow sheet: December 12, 2007 B/P 159/76 March 3, 2008 B/P 168/86 March 12, 2008 B/P 154/78 March 14, 2008 B/P 152/87 March 19, 2008 B/P 159/76 March 26, 2008 B/P 147/76 April 9, 2008 B/P 147/76 June 18, 2008 B/P 163/78 Reported by: Wanda Hardges Mary Davis Corrective Action Required: Tri Health Senior Link should reassess participant¿s blood pressure, when their goals are not being met. Assessments should be conducted to determine if current medications are effective in lowering the blood press blood pressure, and if participant is non-compliance with her medication regimen. The IDT team should develop goals that are individualized for each participant. Notes/Recommendations: Goals on the care plan should be individualized for each participant.

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