PHC TOOL MONITORING INSTRUCTIONS
FY 2007

Reviews are based on requirements found in the Policy Manual. These instructions highlight review procedures. Please note that the manual should always be referred to as the complete reference.

REVIEW CRITERIA	INSTRUCTIONS
I. Program Management	
1. The agency has bylaws/policies establishing a Community Advisory Committee (CAC) that outline:	
a. Frequency of meetings.	The reviewer reads the bylaws/policies establishing the agency's Community Advisory Committee (CAC) to ensure that the frequency of the CAC meetings is clearly stated.
b. Methods to ensure continuity of the CAC.	The reviewer reads the bylaws/policies establishing the agency's Community Advisory Committee (CAC) to ensure that there is a method to ensure that the CAC will continue when members resign from the committee. In accordance with Rider 58, 79th Legislative Session, PHC services must be coordinated with existing Federally Qualified Health Centers (FQHC) located within the counties served by the contractor. At a minimum, this coordination shall be demonstrated by the inclusion of an FQHC representative on the CAC. If an FQHC does not exist within the counties served by the contractor, the membership requirement does not apply.
c. Maintenance of written minutes of the CAC meetings.	The reviewer reads the minutes of the past two CAC meetings noting the date and the following documentation:
i. Minutes reflect the discussion of progress toward meeting performance measures.	Discussion regarding progress made toward meeting performance measures.
ii. Minutes reflect the discussion of current services provided, which are based on a recent community needs assessment.	Discussion regarding: • current services offered in the clinic • services are based on recent community needs assessment (within the past 3 years)

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	• gaps in services • whether or not the agency has the capacity to offer the services for which a gap is noted.
II. Eligibility	The reviewer examines 10 records. If the agency provides services at several sites, 10 records are reviewed at each of the sites visited by the Quality Management team. When possible, three (3) of the records should be of clients who have been or are currently on presumptive eligibility. The reviewer selects the records to be reviewed from monthly billing logs. If a record is not available, select another record for review and inform the team leader so a determination can be made regarding how to mark this section. A finding related to the unavailability of records is noted at the end of the tool in the "Other pertinent information as noted by reviewer" section. Each component of the record review criteria is reviewed individually for compliance. To receive a "Yes," at least 80% of the records reviewed are in compliance with that component. That is, of 10 records reviewed, 8 (or 80%) must receive a "Yes" on that component. **NOTE THE FOLLOWING EXCEPTIONS THAT ARE AUTOMATIC FINDINGS: (1) an eligibility finding resulting in the client's actual ineligibility; (2) overcharging the client for covered services; and (3) billing for services not documented in the client's record.** If a contractor/provider is out of compliance with a component, the "No" is marked with an explanation of which component is not in compliance. Ten (10) records are reviewed at each site visited. The 80% compliance level is applied per site visited. If the agency does not have at least 7 records that contain visits since the agency began the program or since the last review, this service is not reviewed and the team leader will be notified.
1. The agency is utilizing an approved screening and eligibility tool.	The reviewer examines client records for an approved and complete screening/eligibility tool. Approved screening and eligibility tool includes: 1. The Screening and Eligibility Determination Form for Medical Services Assistance 2. DSHS approved agency screening/eligibility form (proof of approval must be available for the QMB Team to review) The reviewer examines the policy and procedure outlining the process for verifying family composition, residency and/or income.

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	The reviewer examines the client records for: 1. A completed Eligibility Determination Form that includes accurate income calculations. The reviewer checks each record for accuracy in the calculation of the client's income based on the current Federal Poverty Level (FPL) and criteria set forth in the Policy Manual. If actual or projected income is not received monthly, it is converted to a monthly amount using one of the following methods: a. weekly income x 4.33 b. every two weeks x 2.17 c. twice a month x 2 See the Policy Manual for self-employment income and other special benefits and exemptions. ***A "No" finding is given if the inaccurate calculation would result in ineligibility.** 2. Supporting documentation for family composition, residence and income 3. Consistent application of agency eligibility policy 4. Medicaid/CHIP denial letters 5. Updating eligibility when family composition, residence, or income change 6. Annual re-certification **Note: The option not to request documentation of family composition, family member Texas residency status, and income are not available for use by PHC as they are for Title V.** If client self discloses pertinent information that will make them ineligible, then no referral to Medicaid or CHIP will be required, but this fact should be documented in the client's record. If the county has additional requirements, which would deny eligibility for County Indigent Health Care Program (CIHCP) this may be documented and the client not referred. Clients waiting for enrollment into CHIP need to have the enrollment date verification form in the chart. **NOTE: Contractors are allowed to continue providing funded services after the initial 90-day period ONLY if the client has applied for CHIP and is waiting on approval, and until the date CHIP enrollment is**

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	effective. ***A "No" finding is given for incomplete items or miscalculation of income that can result in an incorrect determination of eligibility or if the process is done incorrectly or not done.** **(Refer to I.1. of the Eligibility and Billing record review tool).**
2. The Presumptive Eligibility form is completed prior to the receipt of services.	The reviewer checks to see that the Presumptive Eligibility form is completed under appropriate circumstances and as detailed in the PHC Policy Manual. **(Refer to I.2. of the Eligibility and Billing record review tool).**
3. Supplemental services are accurately applied and documented by agency staff.	If the contractor chooses to provide supplemental PHC services to those eligible for Medicare/Medicaid, Title V/XX, the reviewer checks for documentation of PHC eligibility. The notice of eligibility, a card or whatever the contractor uses to describe services MUST clearly delineate what supplemental services are provided by PHC (may use the Notice of Eligibility Form). If the contractor does not enroll clients as supplemental, place a N/A in the box. The agency must ensure the client is not eligible for Medicare Prescription Drug (Part-D) if receiving prescriptive benefits from PHC. **(Refer to I.3. of the Eligibility and Billing record review tool).**
4. A current Statement of Applicant's Rights and Responsibilities form has been completed/signed/dated by all categories of clients and agency staff.	The reviewer checks each client record for a completed/signed/dated Statement of Applicant's Rights and Responsibilities form. Completion of the Statement of Applicant's Rights and Responsibilities form is required for presumptive eligibility. **Note:** The form only needs to be re-signed in the event of a 2-year break in service. **(Refer to I.4. of the Eligibility and Billing record review tool).**
III. Billing	
1. The agency staff is able to demonstrate how client services are billed.	The reviewer asks agency personnel to explain and/or demonstrate how those services that are billed to PHC grant dollars are tracked and monitored to ensure that they were provided to PHC-eligible clients. It is important for contractors to be able to differentiate between those clients and services paid for by PHC grant dollars, and those paid for by other funding sources.

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2. The contractor uses a standard method (such as time sheets, client encounters, or a DSHS approved time study) for allocation of costs.	The reviewer examines the agency's method of allocating costs to the PHC grant. The reviewer inquires whether the agency allocates costs based on time sheets, patient encounters, or a DSHS approved time study. The reviewer asks the agency staff which portions or categories (such as personnel, supplies, contracts, equipment) of the grant are allocated and by which method they are allocated. If the agency does not have a method of allocating costs, this section would be marked "no." If the agency's time study has not been approved by DSHS, this section would also be marked "no."
3. Revenue collected as co-payment from a client whose services are reimbursed with PHC funds must be identified and reported as program income on the Monthly Reimbursement Request for the same month.	The reviewer requests the contractor to provide their method of tracking co-pays and compares it to the same month's submission of the Monthly Reimbursement Request. The contractor may use a monthly log to document co-payments received.
4. If a co-payment is collected, it is accurately and consistently assessed per the agency's co-payment schedule.	The agency may charge up to 25% of the total cost of services. The reviewer checks the client record to verify adherence to this policy. **Note: The contractor must waive co-payment if a client self declares an inability to pay. (Refer to II.2. of the Eligibility and Billing record review tool).**
5. The type of services provided matches the billing log/encounter forms.	The reviewer compares service date documentation in the client record to verify that it matches the service date in the billing log/encounter forms and that the client is eligible for services prior to the delivery of services. The reviewer compares client services documented in the client record to verify that the services match the billed services in the billing log/encounter forms. **(Refer to II.3. of the Eligibility and Billing record review tool).**

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IV. Clinical Record Review	Each component of the record review criteria is reviewed individually for compliance. To receive a "Yes," at least 80% of the records reviewed are in compliance with that component. That is, of 10 records reviewed, 8 (or 80%) must receive a "Yes" on that component. If a contractor/provider is out of compliance with a component, the "No" is marked with an explanation of which component is not in compliance. Ten (10) records are reviewed at each site visited. The 80% compliance level is applied per site visited. If the agency does not have at least 7 records that contain visits since the agency began the program or since the last review, this service is not reviewed and the team leader will be notified. The reviewer uses the protocols, SDOs, and policies established by the agency to complete the record review portion of the review. The agency may use national standards or choose to use DSHS standards for family planning, maternity, immunizations, and diabetes management. Child health services follow Texas Health Steps standards. If a record is not available, select another record for review and inform the team leader so a determination can be made regarding how to mark this section. A finding related to the unavailability of records is noted at the end of the tool in the "Other pertinent information as noted by reviewer" section. When requesting records, the reviewer selects preventative health records or records from a variety of services the agency is providing using its PHC funding.
1. Consent forms to include Method specific and HIV, if applicable, are completed and signed.	The record contains the following consents: 1. General Consent for treatment (**NOTE:** For PHC, parental consent is required for minors receiving PHC services; however, minors may consent to their care related to pregnancy including a pregnancy test**. Scored on the Core Tool)** 2. Method Specific Consent for prescription method of contraception, if applicable, for Family Planning services 3. HIV consent given verbally or in writing is documented, if applicable (**NOTE**: Minors may consent to HIV/STD screening and testing)

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	4. Sterilization Consent Form, if applicable
2. History (initial and interval) is completed to include allergies, risk assessment/identification (family violence, TB, lead, etc.) and immunization status.	The record contains a health history appropriate to the client which includes: 1. Current history 2. Hospitalizations/ surgeries 3. Allergies, sensitivities or reactions to medicines or other substances 4. Family history 5. OB/GYN 6. Sexual behavior history, including family planning practices 7. Mental health history, to include depression and suicidal thoughts or gestures 8. Nutritional history 9. Developmental (pediatric) 10. Immunization history 11. Occupational hazards or environmental toxin exposure The record contains a social history appropriate to the client which includes: 1. Home environment, to include living arrangements 2. Tobacco/alcohol/drugs 3. Family dynamics/problems; e.g., abuse Clients have a health risk assessment according to the following: 1. Children ages birth through 20 years of age have health risk assessments done according to periodicity of visits, e.g., periodicity chart 2. Clients ages 21 years old and older have an initial health risk assessment that is updated annually or if there is a change in client status. Health Risk Assessment includes but is not be limited to: a. Diabetes b. Heart disease c. High-risk sexual behavior d. Violence e. Injury f. Malignancy
3. Physical and developmental assessments are documented.	The record documents a complete physical assessment as applicable. As an integral part of the complete health assessment, the PE is based upon the client's presenting symptoms, review of systems (ROS), past history and

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	health risk factors. The THSteps Medical Checkups Periodicity Schedule for Infants and Children (birth through 9 years) and the THSteps Medical Checkups Periodicity Schedule for Adolescents (ages 10-20 years) is recommended.
4. Appropriate lab/diagnostic tests are ordered, tracked, results reviewed, and the client was notified of abnormal findings	The record contains documentation that lab/diagnostic tests were ordered and tracked, the results were reviewed, and the client was notified of abnormal findings.
5 Education/counseling/anticipatory guidance is documented, as appropriate.	The record contains documentation of education provided for health risks identified in the health risk assessment.
6. Problem management/treatment.	The record contains documentation that problems were managed or treated.
7. Referrals as indicated.	The record contains documentation of referrals, as applicable, including the provision of pertinent client information to the referral source in compliance with HIPAA regulations.
8. Follow-up to include return visit date, missed appointments, and referral outcome.	The record contains documentation of follow-up, including a preventative physical exam, the return visit date, missed appointments, and referral outcome, as appropriate.