IOWA | Health and Human Services

MCAH Service Note Review

Overview

Completing a review of the MCAH database documentation is a quality assurance and quality improvement activity. The purpose is to identify educational opportunities, determine service delivery adjustments, and identify need for correction of inadequate or incomplete documentation through the evaluation of the written documentation within the Maternal Health, Child & Adolescent Health programs. Service Note Reviews apply to Presumptive Eligibility (PE), Informing, and Care Coordination services (including home visit for care coordination) regardless of payer source. Agency staff must be knowledgeable regarding their client's rights under Medicaid.

A review of up to 10 records of each type of service is conducted bi-annually. Reviewers must have knowledge of the program requirements, services, and have access to the Maternal Health (MH) and Child and Adolescent Health (CAH) Data System. Project Directors or Program Coordinators serve as the primary contact for the reviews.

Random Sample Selection

The Iowa Department of Health and Human Services prepares the random samples for reviews and sends them as a Client Data Workbook to the agency via secure email. HHS provides the Service Note Review tools necessary for agencies to conduct these reviews. Agency and HHS teams conduct the review using the same tool.

Tools Used for Service Note Reviews

Client Data Workbook: This form includes the specific client data and service documentation. Therefore, the Client Data Workbook CAN NOT be uploaded into IowaGrants.gov. This contains client information that will be reviewed. Client Data Workbooks are sent by HHS to the agency via secure email.

Service Note Review Summation: HHS will send Service Note Review Summation forms with the Client Data Workbook. Agencies will open the Service Note Review Summations (Child Health: PE, Informing, Care Coordination. Maternal Health: PE, Care Coordination), save as files in your system, complete the forms (including Contact ID & Service Date), and return the completed Summations as directed via secure email. The Service Note Review Summation includes check boxes that the agency completes to indicate the presence of required elements in the documentation. It also includes fields for agency and HHS

summary review comments for each client record. Service note review fields are numbered from Record 1 to Record 10.

Completing Service Note Review

• Complete the Service Note Review Summations by checking the “yes” or “no” boxes to indicate if the required elements of documentation are in the record. Note that the review of Informing services involves the review of follow-ups and completions for the sampled initial informs (as applicable).

• An ‘agency review comment’ field is available for your use for any additional comments. Use of this field is highly encouraged for any items marked no.

• If your agency did not provide a specific type of service to be reviewed, check the ‘No Services This Period’ box on the Service Note Review Summation that verifies this (e.g. if no presumptive eligibility services were provided during the month reviewed).

Process for Submission

Upon completion, return the Service Note Review Summations as directed via secure email. These are due within 30 days from the start of the review process.

Plans for Quality Improvement

Agencies are expected to adhere to the Service Note Review requirements in programming, documenting services provided, training staff, and changing practice if requirements are not met. For agencies that do not achieve 90% documentation compliance, the Service Note Review Quality Improvement Plan is required. 90% compliance will be calculated by summing the total service records submitted for review as the denominator, with the number in compliance as the numerator. Agencies with continued non-compliance may be required to complete quarterly reviews. See a sample template below that includes steps for your plan, person responsible, and projected completion dates -- for implementation as soon as possible (prior to the random selection of client records for the next review).

Plans for Improvement	Person Responsible	Projected Completion Date

Completion

The Quality Improvement Plan should be emailed as directed or within 30 days from the receipt of the Service Note Review Results email from HHS.

Service Note Review Requirements

Presumptive Eligibility

Required Elements:

a. Demographics including race, ethnicity, primary language, and interpreter needed
b. Coverage explained
c. Result of Notice of Action (NOA)
d. NOA number
e. County of residence (Not required for MH)
f. Contacted person
g. Client/family feedback
h. Documents kept on file and documents given to family
i. First and last name of the service provider and their credentials.
j. Intake assessment addressed with IRIS/IRIS component of the MCAH data system used to assess immunization status (Parent/caretaker report is acceptable if it's documented that the service provider does not have access to IRIS or the database system.)

Informing

Initial Inform

Required Elements:

a. First and last name of the service provider and their credentials
b. Statement that an informing letter or packet was sent
c. County of residence

Inform Follow up

Required Elements:

a. First and last name of the service provider and their credentials
b. County of residence
c. Description of the attempt to reach the family and the result of the attempt (no answer, phone disconnected, etc.) including any voicemail message left or text message sent and the content of the message
d. A follow-up letter is sent, (after at least two failed attempts on two different dates)
e. Follow-ups are required within 30 days of the initial inform

Inform Completion

Required Elements:

a. Demographics, including race, ethnicity, interpreter needed, and primary language
b. First and last name of the service provider and their credentials
c. County of residence
d. Contacted person
e. Explanation of full benefits and services available under the EPSDT Program
f. Medical well visit appointment summary (name of provider; past or upcoming appointments)
g. Dental appointment summary (name of provider; past or upcoming appointments)
h. IRIS/IRIS component of the MCAH Data System used to assess immunizations (Parent/caretaker report is acceptable if it's documented that the service provider does not have access to IRIS or the database system.)
i. Client/family feedback provided
j. Referrals, outcomes, and plan for follow-up
k. Intake assessment addressed

Care Coordination

Required Elements:

a. Demographics including race, ethnicity, primary language, and interpreter needed
b. County of residence (Not required for MH)
c. First and last name of the service provider and their credentials
d. Concerns and issues
e. Contacted person
f. Staff response
g. If coordinating medical/dental care:
    i. Dental appointment summary (name of provider; past or upcoming appointments)
    ii. Medical appointment summary (name of provider; past or upcoming appointments)
    iii. IRIS/IRIS component of the MCAH Data System used to assess immunizations (Parent/caretaker report is acceptable if it's documented that the service provider does not have access to IRIS or the database system, or if it's completed by OH staff.)
    iv. Referrals, outcomes, & plan for follow-up
    v. Client/family feedback provided
    vi. Intake assessment addressed

For targeted follow up care coordination notes that do not involve coordinating medical/dental care, the date of the last wellness exam, name of provider, and assessment of immunization status is not required. Indicate in the note if it is a follow-up care coordination service. Address any additional family needs.

Procedure

1. SNR 1 and 2 will be completed between the start of the Federal Fiscal Year and the end of the State Fiscal Year. SNR 1 will occur in the fall/winter of each FFY. SNR 2 will occur in the spring/summer of each FFY. The month selected by HHS for the data pull will be random.
2. For SNR 1, HHS will provide the agency with a list of Contact IDs and blank Service Note Summations (Child Health: PE, INF, CC. Maternal Health: PE, CC).
    a. The agency will review their documentation using the provided forms as a checklist for included elements. Complete the forms (including contact ID & service date) and by checking the "yes" or "no" boxes to indicate if the required elements of documentation are in the record. If there is more than one box marked "no" the record does not "pass." An agency review comment field is available for your use for any additional comments and highly encouraged to explain anything marked no.
    b. If the agency did not provide a specific type of service to be reviewed, check the 'No Services This Period' box on the Service Note Review Summation that verifies this (e.g., if no presumptive eligibility services were provided during the month reviewed).
    c. Completed review tools are to be sent via confidential email, within 30 days from the start of the review process. They should never be uploaded into IowaGrants.gov due to the confidential information they contain.
3. For SNR 2, HHS will provide the agency with completed Service Note Summations (Child Health: PE, INF, CC. Maternal Health: PE, CC).
    a. The agency will use the completed forms and feedback provided by HHS to complete their own quality assurance activity.
4. SNR Quality Improvement Plans are required for agencies that do not achieve 90% documentation compliance for their review. 90% compliance will be calculated by summing the total service records submitted for review as the denominator, with the number in compliance (marked as pass) as the numerator.
    a. Agencies with continued non-compliance will be required to complete more frequent reviews and may be placed on a corrective action plan which may result in the reduction or elimination of funding, or the enforcement of other remedies authorized by the contract.

b. Required elements of the Quality Improvement Plan are the actions that will be taken to assure documentation is following this policy, the person completing this step and responsible for assuring documentation comes into compliance, and the timeline for when the steps will be taken.
c. Quality Improvement Plans should be submitted as directed within 30 days from the receipt of the SNR results from HHS.