SUPERVISORY AUDIT TOOL

(Revised 07/01/2024)

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| Member Name: | |  | | | Case Manager: | |  | |
|  | | |  | |  | | |  |
| AHCCCS ID: |  | | |  | Placement: |  | | |

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|  | | | **N/A** | | | | **YES** | | | | | | **NO** | |
| 1. **NEWLY ENROLLED MEMBERS** | | | | | | | | | | | | | | |
| 1. Was an on-site visit done within 12 business days of enrollment or is there a documented reason in the case file and CA165 for the delay? | | |  | | | |  | | | | | |  | |
| 1. Did LTC services begin within 30 calendar days of enrollment? | | |  | | | |  | | | | | |  | |
| 1. Did case manager confirm delivery of services with member and/or provider and document start date? | | |  | | | |  | | | | | |  | |
| Explain all NO answers: | | |  | | | |  | | | | | |  | |
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| 1. **REASSESSMENTS** | | |  | | | | | | | | | | | |
| Enter # of reviews REQUIRED during last 12 months → |  | |
| Enter # of reviews DONE in last 12 months → |  | |
| 1. Were PCSP reassessment visits completed on time or have documented reason for delay? | | |  | | | |  | | | | | |  | |
| 1. Does the case file contain documentation of a complete assessment of member’s status and needs? If NO, list missing components below. | | |  | | | |  | | | | | |  | |
| 1. Is Level of Care on PCSP consistent with member information in the UAT, HNT (if applicable), and CA160? | | |  | | | |  | | | | | |  | |
| 1. Was the member’s representative contacted if the member was unable to participate in the review? | | |  | | | |  | | | | | |  | |
| 1. Did case manager document in Case Notes and on CA165 the attempts made to contact member, and/or member specific reason review was not completed on time? | | |  | | | |  | | | | | |  | |
| 1. If member had change of placement type, was an on-site visit conducted within 10 days of the change or case manager awareness of change? | | |  | | | |  | | | | | |  | |
| 1. Did the case manager verify that the member is satisfied with their current services at each review? Pgs 15-16 of PCSP and Case Notes | | |  | | | |  | | | | | |  | |
| 1. If member is in a SNF and has an authorized rep (AR) or power of attorney (POA), were they contacted to be included in the review? | | |  | | | |  | | | | | |  | |
| Explain all NO answers: | | |  | | | |  | | | | | |  | |
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| 1. **HOSPITALIZATION**: Documents reviewed for conducting discharge planning for members enrolled with the Tribal ALTCS Program while in the hospital and for existing members who experience a hospitalization: PCSP TOOL, UAT, HNT, FACE SHEET, AND CASE NOTES. | | |  | | | |  | | | | | |  | |
| 1. There is documentation that the Tribal ALTCS CM ensured that adequate/appropriate services are assessed, coordinated, and in place prior to a member’s discharge to his or her own home or to an Alternative HCBS Setting. | | |  | | | |  | | | | | |  | |
| 1. An on-site review was conducted within 10 business days post-discharge from an institutional/in-patient hospital setting. Exception SNF, A23, and back to same SNF no reassessment required post discharge. | | |  | | | |  | | | | | |  | |
| Explain all NO answers: | | |  | | | |  | | | | | |  | |
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|  | | | **N/A** | | | | **YES** | | | | | | **NO** | |
| 1. **SERVICE PLAN / CA165** | | |  | | | |  | | | | | |  | |
| 1. Do service authorizations correspond with case file documentation regarding service types, including correct modifiers, rates, provider, etc.? | | |  | | | |  | | | | | |  | |
| 1. Were requests for service (from member/rep or physician) addressed in a timely manner (decision within 14 calendar days)? | | |  | | | |  | | | | | |  | |
| 1. Does CA165 contain current and open authorizations for services provided? | | |  | | | |  | | | | | |  | |
| 1. Do service authorization dates correspond with placement dates (i.e., no overlap of services across placements, no LTC services for member in “D” placement, etc.)? | | |  | | | |  | | | | | |  | |
| Explain all NO answers: | | |  | | | |  | | | | | |  | |
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| 1. **CES / CA160** | | |  | | | |  | | | | | |  | |
| 1. Does the CES contain appropriate services? | | |  | | | |  | | | | | |  | |
| 1. Was the CES completed at least annually for HCBS members? | | |  | | | |  | | | | | |  | |
| 1. Was a CES completed prior to placement change to HCBS? | | |  | | | |  | | | | | |  | |
| 1. If HCBS percentage exceeds 80% (81% or higher), does the file contain DFSM approval letter or have a timely request (in line with AMPM 1620-C) in process? | | |  | | | |  | | | | | |  | |
| Explain all NO answers: | | |  | | | |  | | | | | |  | |
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| 1. **PLACEMENT / CA161** | | | | | | | | | | | | | | |
| 1. Does CA161 reflect current case manager assigned to case? | | | |  | | | | | | |  | | |  |
| 1. Do placement codes & dates on CA161 correspond with member information (includes Placement Reason and Residence codes)? | | | |  | | | | | | |  | | |  |
| 1. Does Last Review Date correspond with most recent member visit noted in case file? | | | |  | | | | | | |  | | |  |
| 1. If D (Acute Care Only), was an eMCR submitted to AHCCCS to change contract type? | | | |  | | | | | | |  | | |  |
| 1. Did case manager confirm that CA161 reflects AHCCCS Eligibility moved member to “T” placement before moving member to D (Acute Care Only) placement? | | | |  | | | | | |  | | | |  |
| Explain all NO answers: | | | |  | | | | | |  | | | |  |
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| 1. **Community First Choice / CA162** | | | |  | | | | | |  | | | |  |
| 1. Was CA162 entered within 10 business days of the initial visit for newly enrolled members and updated at least annually thereafter? | | | |  | | | | | |  | | | |  |
| 1. Does the information entered on CA162 correspond with other case file documentation regarding Agency with Choice, SDAC, LOC, and Incontinence Status? | | | |  | | | | | |  | | | |  |
| 1. Does BH code on CA161 reflect member’s current status? | | | |  | | | | | |  | | | |  |
| Explain all NO answers: | | | |  | | | | | |  | | | |  |
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| 1. **DOCUMENTATION** | | | |  | | | | | |  | | | |  |
| 1. Was a HCBS Needs Assessment Tool (HNT) completed if member will get in-home services? | | | |  | | | | | |  | | | |  |
|  | | | | **N/A** | | | | | **YES** | | | | | **NO** |
| 1. Does documentation describe member’s informal/unpaid support system and their involvement in care? | | | |  | | | | | |  | | | |  |
| 1. Does documentation reflect ongoing case management monitoring of the member’s needs, an action plan to resolve issues and timely follow-up? | | | |  | | | | | |  | | | |  |
| 1. Is Level of Care on HNT (if HCBS Home setting) consistent with member level of care information in the PCSP, UAT, and CA160? | | | |  | | | | | |  | | | |  |
| 1. **If member is in “Q” Placement**, does documentation reflect case manager consideration of HCBS discharge potential/options? | | | |  | | | | | |  | | | |  |
| 1. Does the file contain evidence of AHCCCS approval for services as indicated (i.e., E1399, DME over $500, Home Modifications)? | | | |  | | | | | |  | | | |  |
| 1. Was an eMCR submitted for all member changes (i.e.: address, placement, ACO, ALTCS Full, etc.)? | | | |  | | | | | |  | | | |  |
| 1. Does documentation indicate Spouse Attendant Care was offered as an option if member is married? | | | |  | | | | | |  | | | |  |
| 1. If Spouse Attendant Care is authorized, is Spouse Acknowledgement form reviewed and signed at least annually? | | | |  | | | | | |  | | | |  |
| Explain all NO answers: | | | |  | | | | |  | | | | |  |
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| 1. **BEHAVIORAL HEALTH** | | | |  | | | | |  | | | | |  |
| 1. If the member is on psychotropic medications, does the case manager document effectiveness and side effects at each review? | | | |  | | | | |  | | | | |  |
| 1. Does BH code on CA161 reflect member’s current status? | | | |  | | | | |  | | | | |  |
| 1. Were initial and quarterly discussions for members who are **not** stable on psychotropic medications conducted/documented in the case file with the member/authorized rep? | | | |  | | | | |  | | | | |  |
| 1. Did the case manager assess the need for and appropriately send referrals for Serious Mental Illness (SMI) determinations as specified in AMPM Policy 320-P to a qualified clinician? | | | |  | | | | |  | | | | |  |
| 1. Did the case manager ensure there is communication with and coordination between the member’s Primary Care Provider (PCP) and behavioral health providers involved in the member’s care and that care is also coordinated with other agencies and/or other providers involved in the member’s care? | | | |  | | | | |  | | | | |  |
| 1. For members residing in a non-behavioral health setting and exhibiting challenging behaviors (new or existing), did the case manager ensure the timely involvement of a Behavioral Health Professional (BHP) to assess, develop a care plan and preserve the current placement (if possible)? Refer to AMPM Policy 310-R for information on acute behavioral health situations. | | | |  | | | | |  | | | | |  |
| 1. Did the case manager document the content and results of the initial and quarterly discussions with the BHP that includes the member’s current status and plan of treatment? | | | |  | | | | |  | | | | |  |
| Explain all NO answers: | | | |  | | | | |  | | | | |  |
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| 1. **OLMSTEAD PLAN** Questions in this section relate to Olmstead Plan which is intended to remove unnecessary segregation of members from the broader community and ensuring members/guardians have the opportunity to make informed decisions and choices regarding how their medical and behavioral health needs can best be met in community-based (or institutional) settings, thereby creating more potential opportunities for members to elect voluntary treatment and the least restrictive setting in the community to meet their needs. | | | | | | | | | | | | | | |
| 1. Was the member’s Voice and Choice heard regarding their Placement and the Choice of Provider? | | | |  | | | | |  | | | | |  |
| 1. Was the Workforce Development option discussed with the member, if applicable? | | | |  | | | | |  | | | | |  |
|  | | | | **N/A** | | | | | **YES** | | | | | **NO** |
| 1. Was the member’s needs and progress towards personal goals and desired outcomes accomplished? | | | |  | | | | |  | | | | |  |
| 1. Is the PCSP being reviewed with the member/guardians and revised at least annually (for ACO)? | | | |  | | | | |  | | | | |  |
| 1. Auditor has verified that the PCSP was signed by the member/guardian at each review visit? | | | |  | | | | |  | | | | |  |
| 1. If the member is at risk of being institutionalized, was it discussed in one of the PCSP’s with the member/guardian to safely integrate the member into the least restrictive setting, such as a step-down plan? | | | |  | | | | |  | | | | |  |
| 1. Are the services being provided (the type, scope, amount, duration, and frequency) those that will assist the member in being placed in the least restrictive setting? | | | |  | | | | |  | | | | |  |
| Explain all NO answers: | | | |  | | | | |  | | | | |  |
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| 1. **UNIFORM ASSESSMENT TOOL** | | | | |  | | |  | | | | | |  |
| 1. Does file contain completed and up-to-date Uniform Assessment Tool? | | | | |  | | |  | | | | | |  |
| 1. Is Level of Care on UAT consistent with member level of care information in the PCSP, HNT (if HCBS Home setting), and CA160? | | | | |  | | |  | | | | | |  |
| Explain all NO answers: | | | | |  | | |  | | | | | |  |
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| 1. **NOTICE OF ACTION** | | | | |  | | |  | | | | | |  |
| 1. If services were denied, was a written Notice of Adverse Benefit Determination (NOA) sent to the member? | | | | |  | | |  | | | | | |  |
| 1. If services were reduced/terminated, was a written NOA sent if member did not agree with the change (marking Disagree on Service Plan)? | | | | |  | | |  | | | | | |  |
| 1. If YES to A or B, was the NOA sent within established timelines, to the member and/or representative, and a copy kept in the case file? | | | | |  | | |  | | | | | |  |
| 1. If YES to A or B, does documentation support the decision? | | | | |  | | |  | | | | | |  |
| Explain all NO answers: | | | | |  | | |  | | | | | |  |
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| **ADDITIONAL COMMENTS** (include auditor’s assessment of quality of documentation) | | | |
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| Auditor: |  | | | | Date audited: | | | |  | |
|  | |  | | |  | | |  | | |
| Date reviewed with case manager: | | | |  | | |  | | |  |
|  | | |  | |  | | | | |  |
| Case manager’s signature acknowledging receipt: | | | | | |  | | | | |

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