Audiological Services Quality Assurance Checklist			
Review Period: 2024-2025		**Date:**	
Student:		**Medicaid #:**	
District:		**Reviewer:**	
Provider (Staff Name):		**Provider (Staff Name):**	
Supervisor:		**Supervisor:**	
CONSENT(S)		**MET**	**COMMENTS/RECOMMENDATIONS**
Reference – LEA Manual, Part I, Chapter 6: Reporting/Documentation – Clinical Records.			
1.1	Is there a General Consent form signed and dated (electronically or handwritten) by the student's parent or guardian authorizing treatment?		
1.2	Is there a Release of Information form signed and dated (electronically or handwritten) by the student if 18 or older, the student's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims on behalf of the student?		
REFERRAL(S)		**MET**	**COMMENTS/RECOMMENDATIONS**
Reference – LEA Manual, Part I, Chapter 6: Reporting/Documentation - Referrals			
2.1	Is there a written referral form to cover the year in review?		
2.2	Is the referral form signed, titled, and dated (electronically or handwritten) by a physician or other authorized Licensed Practitioner of the Healing Arts (LPHA)? Note: Refer to the OMS LPHA Referral document on the OMS webpage.		
2.3	Is the referral form completed by a LPHA other than the direct provider of services?		
2.4	Is the referral form dated prior to the evaluation/re-evaluation?		
2.5	Is the referral form dated prior to the first date of service rendered in the year in review?		
EVALUATION/RE-EVALUATION		**MET**	**COMMENTS/RECOMMENDATIONS**
Reference – LEA Manual, Part I, Chapter 4: Covered Services and Definitions - Evaluations			

3.1	Is there an evaluation/re-evaluation to cover the year in review?		
3.2	Does the evaluation/re-evaluation include the signature, title, and date (electronically or handwritten) of the Audiologist?		
3.3	Does the evaluation include a comprehensive audiometry threshold test record that identifies the need for rehabilitative therapy services?		
3.4	Does the evaluation include a written report with recommendations?		
3.5	Is the annual evaluation/re-evaluation dated prior to the first date of service rendered in the year in review?		
CLINICAL SERVICE NOTES (CSNs)		**MET**	**COMMENTS/RECOMMENDATIONS**
Reference – LEA Manual, Part I, Chapter 6: Clinical Records – CSN			
4.1	Are there CSNs present to support all billed claims?		
4.2	Is each CSN signed, titled, and dated (electronically or handwritten) by the provider?		
4.3	Do the CSN(s) include the date of service?		
4.4	Is the documentation sufficient to support the number of units billed to Medicaid?		
4.5	Is each CSN individualized and student specific?		
4.6	Do the CSN(s) include the child's response to treatment?		
PERSONNEL RECORDS		**MET**	**COMMENTS/RECOMMENDATIONS**
Reference – Provider Administrative and Billing Manual, Chapter 1: General Information and Administration – Verification of Provider License, Certifications and/or Credentials.			
5.1	Is the staff's SCLLR credentials current and present in the staff's file? (Copies must be stored in the credential file or student's file).		
5.2	Are staff credentials checked via the SCDHHS OIG Exclusion list and printed with date stamp during the year in review? (Copies must be stored in the credential file or the student's file.)		

5.3	Are the staff credentials checked via the Federal OIG Exclusion list and printed with date stamp during the year in review? (Copies must be stored in the credential file or student's file.)		
CLINICAL RECORDS AND MAINTENANCE		**MET**	**COMMENTS/RECOMMENDATIONS**
Reference – LEA Manual, Part I, Chapter 6: Reporting/documentation – Clinical Records, - Records Maintenance.			
6.1	Is the documentation typed or legibly handwritten in dark ink?		
6.2	Are errors corrected according to Medicaid policy and procedure (i.e., draw one line through the error, enter the correction and add signature/initials and date next to the correction)?		
6.3	Is there an abbreviation and symbols key available and on file?		
6.4	Is there a signature sheet available that identifies staff's name, signature, and initials in the file?		
Third-Party Liability (TPL) Requirements		**MET**	**COMMENTS/RECOMMENDATIONS**
Reference – Provider Administrative and Billing Manual, Chapter 1: Extent of Provider Participation – Medicaid as Payment in Full, - Health Insurance, - Provider Responsibilities – TPL; Chapter 2: Billing Procedures – Third-Party Liability (TPL).			
7.1	Is there an Eligibility Verification completed with date stamp during the year in review that identifies a third-party insurer?		
7.2	Is there an Explanation of Benefits (EOB) in the record to reflect payment or denial?		
7.3	Is there a TPL letter present in the record which states a third-party insurer does not cover the service?		