CHART & PROVIDER REVIEW

1. Client Identification

Client Mask ID #

2. Agency Identification

Provider Mask RU #

3. Episode Opening Date (EOD)

Dates of the audit period?

What is the Authorization Cycle for this chart?

What is the due date of the Assessment to cover the services within the audit period?

What is the due date of the Treatment Plan to cover the services within the audit period?

If authorization cycle splits audit period, what is the due date of second required Assessment / Treatment Plan?

4. ASSESSMENT STAFF 1

Last name, First initial

5. ASSESSMENT STAFF 2

Last name, First initial

6. CT PLAN STAFF 1

Last name, First initial

7. CT PLAN STAFF 2

Last name, First initial

8. PN STAFF 1

Last name, First initial

9. PN STAFF 2

Last name, First initial

10. MD/NP

Last name, First initial

ACBHCS CHART REVIEWER

Last name, First initial

PES / CRISIS STABILIZATION PROGRAMS SKIP LOGIC

Is this a PES or Crisis Stabilization Program?
(Claims sheet should show claim as "221 Crisis Stabilization" This service is billed per minute)

- ◯ Yes (answer Crisis Stabilization Program / PES questions)
- ◯ No (answer Screening questions)

SCREENING QUESTIONS

11. The most recent required ACBHCS Screening Tool for the audit period has been completed -correct version for age (0-5, 6-17, or 18+) with proper signatures - prior to the initial opening of the client episode or prior to the reauthorization of services? (Screening Tool should be completed before opening the case and before every Annual Assessment due date and every Plan Update for all clients). [yes=100% no=0% *N/A = 999]

Note: The Screening Tool must be completed by a Licensed, registered, or waivered LPHA and must contain the co-signature of a Licensed LPHA if completed by a registered or waivered LPHA.

**Screening Tool is N/A for the following providers:*

- *OUT OF COUNTY PROVIDERS*
- *TBS WORKERS--AS OVERSEEING CLINICIAN ALREADY DOES IT*
- *CRISIS PROGRAMS (PES, CSU, MCT)*
- *CONSERVATORSHIP PROGRAM*
- *STAT PROGRAM (WEST COAST)*
- *GUIDANCE CLINIC*

◯ 0 ◯ 100 ◯ 999

12. For all required Brief Screening Tools, the mental health condition meets the criteria for Moderate to Severe? (If either is out = 0%) [yes=100% no=0% NA=999]

- If Brief Screening Tool is required but not present, score 0 for this item and auditor should comment that provider needs to complete a screening tool asap for client to remain in treatment.
- If Brief Screening Tool indicates that the client should be referred to a lower level of care, score 0 and comment that the provider must refer client to a lower level of treatment.

    - For clients 18+ disallow all claims after the date that the Brief Screening Tool indicates client should have been referred to a Mild-Moderate Provider. May include claims outside of the audit period (please let CRS know).
    - We do not currently disallow claims for children 17 and under even if they don't meet criteria for moderate to severe. If a child's screening form indicates that they do not meet criteria for moderate to severe, score 0, and give a comment, but do not disallow any claims.

DHCS reason for recoupment:
#19a6b - The completed Brief Screening Tool (Mild-Moderate vs. Moderate-Severe) for a client 18 years and older indicated that they should have been referred to a Mild-Moderate Provider.

◯ 0 ◯ 100 ◯ 999

INFORMING MATERIALS QUESTIONS

13. The most recent required ACBHCS Informing Materials signature page is completed *in client's/representative's primary or preferred threshold language and completed within required time frame (see below)?* [yes=100% no=0%] (Auditor to comment if present but late or present but not provided in a threshold language. Score 0 if late.)

Threshold Languages: Spanish, Chinese (Cantonese, Mandarin), Farsi, Vietnamese, Korean, Tagalog

Form Requirements:

Initial form is due by assessment due date. It is required to be signed/dated by beneficiary (or legal representative) and initialed/dated by clinician/staff. Informing materials are required to be reviewed annually by date of admission as indicated by beneficiary/legal representative's initials & date. If late, reason is documented in progress notes.

◯ 0 ◯ 100 ◯ 999

MEDICAL / SERVICE NECESSITY QUESTIONS

14. For the full audit period, documentation establishes a primary DSM diagnosis from appropriate DHCS Medi-Cal Included list (see diagnosis requirements below). [yes=100% no=0% N/A=999]

DHCS reason for recoupment (chose only topmost reason e.g. if #1a then don't chose #1b or subsequent)
#1a - Before 30 days—Initial Assessment not past due and Planned Services have been provided where full Medical-Necessity has not been established in each Planned Services Progress note (by Licensed LPHA; Waivered/Registered LPHA-which requires Licensed LPHA co-signature for Diagnosis-or indication Dx made by an identified Licensed LPHA with date; or MH Trainee with Licensed LPHA co-signature and indication of Dx made by an identified Licensed LPHA with date).
#1b - Assessment past due.
#1c - Assessment not signed by Licensed/Waivered/Registered LPHA, or Trainee with Licensed LPHA co-signature.
#1d - Non-Included Diagnosis.
#1e - Documentation in the Assessment does not support the included diagnosis. (DSM Diagnostic Criteria is not met, or adequately documented, for a M/C Included Diagnosis.)
#1f - Diagnosis is not established by licensed LPHA OR not co-signed by licensed LPHA if established by a waivered staff or registered intern.

Notes:
• Score 0 if this requirement is not met for the full audit period.
• After 30 days or until assessment is completed (whichever comes first) disallow all claims until medical necessity requirement is met.
• If #1 is disallowed also disallow for #2, #3, and #4 on claims sheet.
• If SM14 is out then SM15, SM16, and SM17 are also out. Please score accordingly.

Diagnosis requirements by date:
1) Before 10/1/15: DSM-IV Name and/or ICD-9 Code from DHCS DSM-IV Included list
2) 10/1/15 to 3/31/17: DSM-IV Name AND ICD-10 code from DHCS DSM-IV Included list
3) After 4/1/17: DSM-5 Name & ICD-10 Code from DHCS DSM-5/ICD-10 Included list
a) If name or code are present score 0 and make comment that both should be included
b) If both name and code are missing, score 0 and comment that there is no included diagnosis
c) If client has a DSM-IV diagnosis after first face-to-face after 4/1/17, please consult with CRS as needed to determine grace period requirements.

◯ 0 ◯ 100 ◯ 999

15. For the full audit period, Impairment Criteria - Documentation establishes that, as a result of the primary diagnosis, there is at least one of the following:

- Significant impairment in important area of life functioning;
- Probable significant deterioration in an important area of life functioning;
- Probable the child won't progress developmentally, as appropriate;
- If EPSDT: MH condition can be corrected or ameliorated. [yes=100% no=0% N/A=999] (Auditor to look at assessment for audit period).

DHCS reason for Recoupment #2:

- Documentation in the Assessment does not support the impairment criteria; OR
- The condition can be treated in a physical health care based setting only.

Notes:

- Score 0 if this requirement is not met for the full audit period.
- After 30 days or until assessment is completed (whichever comes first) disallow all claims until medical necessity requirements are met.
- If #2 is disallowed also disallow for #3 and #4 on claims sheet.
- If SM15 is out then SM16 and SM17 are also out. Please score accordingly.

◯ 0 ◯ 100 ◯ 999

16. For the full audit period, documentation establishes that the focus of the proposed intervention addresses the condition of the primary diagnosis as it relates to:

- Significant impairment in important area of life functioning;
- Probable significant deterioration in an important area of life functioning;
- Probable the child won't progress developmentally, as appropriate;
- If EPSDT: MH condition can be corrected or ameliorated. [yes=100% no=0%] (Auditor to look at assessment & client plan for audit period) [yes=100% no=0% N/A=999]

DHCS reason for Recoupment #3:

- Documentation in the Assessment and/or Client Plan does not establish proposed intervention criteria; OR
- The condition can be treated in a physical health care based setting only.

Notes:

- Score 0 if this requirement is not met for the full audit period.
- After 60 days or until plan is completed (whichever comes first) disallow all claims until medical necessity requirements are met.
- If #3 is disallowed also disallow for #4 on claims sheet.
- If SM16 is out then SM17 is also out. Please score accordingly.

◯ 0 ◯ 100 ◯ 999

17. For the full audit period, documentation establishes the expectation that the proposed intervention will do, at least, one of the following:

- Significantly diminish the impairment;
- Prevent significant deterioration in an important area of life functioning;
- Allow the child to progress developmentally, as appropriate;
- For EPSDT: Correct or ameliorate the condition. (Auditor to look at assessment & client plan for audit period) [yes=100% no=0% N/A=999]

DHCS reason for Recoupment #4:

- Documentation in the Assessment and/or Client Plan does not establish proposed intervention criteria;OR
- The condition can be treated in a physical health care based setting only.

Notes:

- Score 0 if this requirement is not met for the full audit period.
- After 60 days or until plan is completed (whichever comes first) disallow all claims until service necessity requirements are met.
- If SM14, SM15 and SM16 are out then SM17 is out. Please score accordingly.

◯ 0 ◯ 100 ◯ 999

ASSESSMENT SKIP LOGIC

Regarding the Initial Assessment, choose one:

- ○ The Intial Assessment has not yet been completed AND episode has been open LESS THAN 30 DAYS. (go to Client Plan skip logic)
- ○ The Initial Assessment has been completed OR episode has been open MORE THAN 30 DAYS. (answer assessment questions)

ASSESSMENT QUESTIONS

18. The most recent required Assessment includes presenting problems and relevant conditions? [yes=100% no=0%]

◯ 0 ◯ 100

19. The most recent required Assessment includes psychosocial history including: 1) living situation, 2) daily activities, 3) social support, and 4) history of trauma or exposure to trauma? [% correct = categories present/4]

Percent Compliant

20. The most recent required Assessment contains information about current and past psychiatric medications (or lack thereof) the client has received, including duration of medical treatment? Scoring categories: 1) current psychiatric meds, 2) duration of treatment with current psychiatric meds, 3) past psychiatric meds, 4) duration of treatment with past psychiatric meds. [% correct = categories present/4; 100% if lack thereof is noted]

Percent Compliant

21. The most recent required Assessment contains information about current and past medications to treat medical conditions (or lack thereof) the client has received, including duration of medical treatment? Scoring categories: 1) current meds, 2) duration of treatment with current meds, 3) past meds, 4) duration of treatment with past meds. [% correct = categories present/4; 100% if lack thereof is noted]

Percent Compliant

22. The most recent required Assessment includes a mental status exam (MSE)? [yes=100% no=0%] (Note that all noted abnormal findings or impairments must be described to receive credit for this item. Score as 0 if this occurs but do not disallow claims)

If no MSE disallow, or disallow until present. If MSE is found in another part of the chart consult with CRS.

Reason For Recoupment:

#1e - Documentation in the Assessment does not support the included diagnosis. (DSM Diagnostic Criteria is not met, or adequately documented, for a M/C Included Diagnosis.)

◯ 0 ◯ 100

23. For the most recent required Assessment, Risk(s) to client assessed? [yes=100% no=0%]
(For credit, Danger to Self must be assessed and if indicated, a description is required. Additional risk areas to be assessed *and addressed-only if clinically indicated*: Prior suicide attempts; hospitalizations for DTS, lack of family or other support, prior arrests, on probation, history of ETOH/Drug abuse, history of self-harm, & physical impairment which makes vulnerable to others--limited vision/deaf/wheelchair bound.)

◯ 0 ◯ 100

24. For the most recent required Assessment, Risk(s) to others assessed? [yes=100% no=0%]
(For credit, Danger to Others must be assessed and if indicated, a description is required Additional risk areas to be assessed *and addressed-only if clinically indicated*: hospitalizations for DTO, lack of family or other support, prior arrests, on probation, history of ETOH/Drug abuse, history of assaultive behavior.)

◯ 0 ◯ 100

25. The most recent required Assessment includes pre/perinatal events and relevant/significant developmental history for youth? [yes=100% no=0% Adult=999]

◯ 0 ◯ 100 ◯ 999

26. Documentation of the client/family strengths in achieving client plan goals or objectives are included in most recent required Assessment or most recent required Client Plan? [yes=100% no=0%]

◯ 0 ◯ 100

27. Allergies/adverse reactions/sensitivities OR lack thereof are noted in the record? [yes=100% no=0%]

◯ 0 ◯ 100

28. Allergies/adverse reactions/sensitivities OR lack thereof are noted prominently on the chart cover, or if an EHR, it is in the field/location designated by the clinic? [yes=100% no=0%]

◯ 0 ◯ 100

29. For the most recent required Assessment, relevant medical conditions/hx or lack thereof noted including the name of current source of medical treatment (current provider and provider's address required even if no medical conditions for annual exams)? Scoring categories: 1) medical conditions, 2) name of current provider or "none" indicated even if no medical conditions, 3) address of current provider. (If none noted for PCP, Quality Comment that they should have referred them for Primary Care. [% correct = categories present/3; 100% if lack thereof is noted]

Percent Compliant

30. For the most recent required Assessment, mental health history noted including 1) previous treatment (including inpatient admissions), 2) previous providers, 3) therapeutic modalities, and 4) response [% correct = categories present/4; 100% if "no previous mental health history" is noted]

Percent Compliant

31. For the most recent required Assessment, past and present substance exposure/substance use of tobacco, alcohol, caffeine, CAM, OTC drugs, illicit drugs, and use (other than as prescribed) of Rx drugs assessed & noted? [# compliant/7 or 14% each]

Percent Compliant

32. Required CFE/CANS/ANSA/ANSA-T are completed (and is in the medical record, not just in Objective Arts) for relevant audit period? [# correctly completed / # required; N/A=999]

• Effective 9/1/15 CANS/ANSA-T are required for children and Transition Aged Youth (replaces CFE).
• Effective 12/5/16 ANSA is required for adults and CFE is no longer required (for all clients).

CFE was due initially within 60 days and annually at EOD thereafter.

CANS/ANSA/ANSA-T all have the same date/cycle requirements: Must be completed with the client/family within 60 days of the episode opening date, prior to the treatment plan completion. They will be reviewed and updated with the client/family by 6 months from the admit date - or more frequently if clinically indicated to measure progress. All must be redone before a treatment plan is revised. A closing one must be done at discharge.

Notes:

- For TBS programs there is a primary mental health clinician that is required to complete the CFE/CANS/ANSA-T. The primary mental health clinician may be at a different agency than the TBS program.
- Level III, Inpatient, crisis programs, conservatorship, meds only, and out of county programs are not required to complete CANS/ANSA/ANSA-T.
- Full Service Partnership (FSP) programs were never required to complete CFEs. As of 12/5/2016 FSPs were required to complete CANS/ANSA/ANSA-T.
- Non f-f CFE/CANS/ANSA codes became effective 7/1/15.
- CANS/ANSA/ANSA-T may only be completed by a Licensed OR Waivered/Registered LPHA OR MH Student-Trainee with Licensed LPHA co-signature.
- CANS/ANSA/ANSA-T must be in the Medical Record (not just in Objective arts). If the forms are not in the Medical Record, score 0 and give a quality comment.

Percent Compliant

33. Assessment(s) (initial and annual) required during the audit period are completed and signed by all required participants on time. [% correct = # of assessments in compliance / # assessments required]
Required Assessment Signatures:
1.) Licensed LPHA (Not RN only), OR
2.) Registered / Waivered LPHA--co-sig only needed on Assessment if Dx is made--or none on Assessment if Dx is specifically co-signed, OR
3.) Trainee with Licensed LPHA co-sig on Assessment (and cannot make Dx).

DHCS Reason for Recoupment:
#1b - Assessment past due; AND/OR
#1c - Assessment not signed by Licensed/Waivered/Registered LPHA, or Trainee with Licensed LPHA co-signature.

Notes:
• If #1 is disallowed also disallow for #2, #3, #4 on claims sheet.
• Disallow all claims past 30 days of EOD and any claims other than assessment and plan development before 30 days until criteria is met. For annual assessments, disallow all claims past due date of the assessment.
• If the client plan has been completed prior to completion of the assessment, auditor to provide comment.
• Residential (Adult & Crisis, Day Rehab, and DTI require a completed Assessment within 72 hrs. effective -- pending.

Percent Compliant

CLIENT PLAN SKIP LOGIC

Regarding the Client Plan, choose one:

- ○ The Client Plan HAS NOT been completed AND the episode HAS been open LESS than 60 days. (answer special needs questions)
- ○ The Client Plan HAS been completed OR the Client Plan HAS NOT been completed and the episode has been open MORE than 60 days. (answer client plan questions)

CLIENT PLAN (FOR AUDIT PERIOD) QUESTIONS

34. Are all Client Plans for the audit period completed and signed on time by all required staff (other than MD)? Note: Non-LPHA (Adjunct, Trainee, and MHRS staff) require Licensed LPHA co-signature [% correct = # of plans in compliance / # of required plans]

DHCS reason for Recoupment (list all that apply):
#5b - No Initial Client Plan.
#5c - Initial Client Plan is late.
#5d - Initial Client Plan is missing required staff signature(s) for date of service.
#6b - No Annual Client Plan or Plan Update for date of service.
#6c - Annual Client Plan is late.
#6d - Annual Client Plan is missing required staff signature(s) for date of service.

---Disallow claims from date due until date Plan is completed and signed by required staff. If missing MD signature only DO NOT disallow claims for this reason only
Note: Residential (Adult & Crisis), Day Rehab, and DTI require a completed Plan within 7 calendar days effective -- pending..

Percent Compliant

35. The objectives listed in all Client Plans for the audit period are current (not expired per written effective dates for the dates of service related to them) Mental Health Objectives and directly address the symptoms/impairments of the included diagnosis [% correct = # of compliant objectives / total number of objectives listed]
Note: Out if no Plan and calculate based on 1 mental health objective missing for that plan.

--There must be at least one current (not expired) mental health objective on the Client Plan that addresses the symptoms/impairments of the included diagnosis in order to claim for services. If none, disallow all claims until criteria met.

DHCS Reason for Recoupment:
#5e - There is not a current (not expired) mental health objective in the Initial Client Plan.
#6e - There is not a current (not expired) mental health objective in the Annual Client Plan.

Percent Compliant

36. The Mental Health Objectives listed in the most recent required Client Plan are observable/measurable with time frames (both elements required for compliance) [% correct = # of compliant objectives / total number of objectives]

Percent Compliant

37. All Client Plans for the audit period list proposed Service Modalities. [% correct = sum of listed current service modalities / total number of required service modalities indicated by claimed services across all plans]
Note: Out if no plan.

DHCS Reason for Recoupment:
#5f - Service modality claimed is not indicated in Initial Client Plan.
#6f - Service modality claimed is not indicated in Annual Client Plan.

--If a Service Modality is not listed (or if the Service Modality time frame is expired) for planned mental health services, disallow related claims. Auditor to check claims form to make sure services claimed are listed and current on relevant Client Plan. The only MH Services that the Client Plan does not need to list: Assessment, Plan Development, Crisis Psychotherapy, and Interactive Complexity. Pending collateral - if collateral is not listed on Client Plan, do not disallow related claims.

Percent Compliant

38. For the most recent required Client Plan, the frequency and time frames are listed for each Service Modality?

Service Modalities which must be listed in Client Plan:

- *Collateral (requirement pending),*
- *Case Management,*
- *Medication Services,*
- *Individual Therapy,*
- *Individual Rehabilitation,*
- *Group Therapy,*
- *Group Rehabilitation,*
- *Family Therapy (Includes Single Family and Multi-Family Group)*
- *TBS,*
- *Katie A (ICC, and/or IHBS),*
- *Day Rehabilitation (1/2 or Full Day),*
- *Psychological Testing (Includes Psych Test, Developmental & Neuropsych),*
- *Residential (Includes Adult and Crisis).*

Those not required to be in Plan:

- *Assessment (includes w/ and w/o medical & CANS/ANSA).*
- *Plan Development,*
- *Crisis Therapy & Crisis Stabilization, and*
- *Interactive Complexity.*
- *Collateral (for the time being)*

[% correct = sum of compliant service modalities / total number of service modalities]

Percent Compliant

39. The most recent required Client Plan describes detailed provider interventions for each service modality listed in the Plan? [% = # of service modalities listed in Plan that have a detailed description/total number of service modalities claimed that are - or should have - been listed in the Plan]

Percent compliant

40. For the complete audit period, Risk(s) (within the last 90 days of indication of risk or potential risk) to client (DTS) have plan for containment if applicable? [yes=100% no=0% N/A=999] (Review assessment, safety plan or client plan; if no client plan yet, review PN's and other documentation.) Note: if risk to client has not been assessed or if unable to determine if there is a risk to client within the last 90 days because it has not been assessed adequately, no credit given for this item.

◯ 0 ◯ 100 ◯ 999

41. For the complete audit period, Risk(s) (within the last 90 days of indication of risk or potential risk) to others (DTO) have a plan for containment if applicable? [yes=100% no=0% N/A=999] (Review assessment, safety plan or relevant client plan; if no client plan yet, review PN's and other documentation.) Note: if risk to others has not been assessed or if unable to determine if there is a risk to others within the last 90 days because it has not been assessed adequately, no credit given for this item.

◯ 0 ◯ 100 ◯ 999

42. For the complete audit period, Coordination of care is evident, when applicable [yes=100% no=0% N/A=999] (Review Client Plan, Progress Notes, and/or other documentation.)

◯ 0 ◯ 100 ◯ 999

43. For the complete audit period, the Client Plan is updated when there are significant changes in service, diagnosis, focus of treatment, etc. [yes=100% no=0% N/A=999] (auditor to review progress notes before scoring this item. If a potentially significant issue is present, auditor to review with CRS).

Includes: hospitalizations, risk to self/others, decompensation, etc.

DHCS reason for Recoupment:
#6g - Plan is not updated (re-written) when clinical need arises.

--Disallow from date update required until completed for SI, HI, hospitalizations, major change in Dx.

◯ 0 ◯ 100 ◯ 999

44. Is the most recent required Client Plan signed/dated by MD/NP if applicable? [yes=100% no=0% N/A=999] (MD/NP signature is required if client is receiving medication or under care of MD/NP from clinic)

◯ 0 ◯ 100 ◯ 999

45. Are all Client Plans for the audit period signed/dated by client or legal representative when appropriate or documentation of client refusal or unavailability? [% correct = # of plans in compliance / # of required plans, N/A=999]
Note: If the client plan is completed but does not contain the client's signature, choose N/A if audit period is before the client plan due date and add comment.

DHCS reason for recoupment:
#7a - No client (or guardian) signature on Client Plan for date of service, w/o documentation of reason.
#7b - Late client (or guardian) signature on Client Plan for date of service, w/o documentation of reason.

--Disallow from date due until signature obtained or reason indicated. If there is no date on client signature -currently this alone is not reason for disallowance.

Percent Compliant

46. Does the most recent required Client Plan (or related progress note) include documentation of the client's participation in and agreement with the Client Plan? [yes=100% no=0% N/A=999] (Auditor to give credit for this item if there is only a client (or guardian) signature on the Client Plan and provide comment that provider should include a statement of the client's participation and agreement with the client plan in the client plan or associated PN)
Note: If the client plan is completed but does not contain the client's signature, choose N/A if audit period is before the client plan due date and add comment.

◯ 0 ◯ 100 ◯ 999

47. Does the most recent required Client Plan indicate that the client/representative (signatory) was offered a copy of the plan? [yes=100% no=0% N/A=999]

Notes:
If the client speaks a threshold language (*Spanish, Cantonese, Mandarin, Farsi, Vietnamese, Korean, Tagalog*), in order to receive credit for this item: The plan or related progress note contains a statement to indicate "the client was offered a copy of the client plan in their threshold language" or a statement to indicate that the provider explained, or offered to explain the plan to the client in their threshold language, OR, there should be a copy of the client plan in the client's threshold language.

If the client plan is completed but does not contain the client's signature, choose N/A if audit period is before the client plan due date and add comment.

◯ 0 ◯ 100 ◯ 999

48. Does the most recent required Client Plan contain a Tentative Discharge Plan (anticipated timeframe, readiness indicators and/or possible referrals at d/c)? [yes=100% no=0%]

◯ 0 ◯ 100

TBS SKIP LOGIC

Did client receive TBS during the audit period?

- ◯ Yes (Answer TBS questions)
- ◯ No (Skip to next section)

THERAPEUTIC BEHAVIORAL SERVICES (TBS) QUESTIONS

49. In order to qualify for TBS services, client/youth must meet one of the following criteria (to establish TBS Certified Class Membership):

- Currently placed in a RCL12 or above group home and/or locked treatment facility
- Being considered by the county for a RCL 12 or above group home and/or locked treatment facility
- At least one psychiatric hospitalization in the preceding 24 months related to current presenting disability
- Previously received TBS while a member of the certified class
- Client is at risk of requiring psychiatric hospitalization.

If no criteria are met, score 0, provide comment, and disallow all TBS claims. [yes=100% no=0%]

DHCS/ACBHCS Reason For Recoupment:
#8a - Documentation of TBS *Class Certification* is not in the chart and is not provided upon request. TBS *Class Certification* requires M/C beneficiaries be under the age of 21 and meetone of the following criteria: Is placed in RCL 12 or above and/or another locked treatment facility for the treatment of mental health needs; Is being considered for placement in a locked treatment facility; Is at risk of psychiatric hospitalization; Has been psychiatrically hospitalized in the past 24 months; Previously received TBS while a member of the certified class.

◯ 0 ◯ 100

50. For each TBS claim during the audit period, does the progress note clearly indicate that TBS was provided for one of the following reasons? [% Compliant = Compliant TBS claims/Total TBS claims]

• For the convenience of of the family, caregivers, physician, or teacher;
• To provide supervision or to ensure compliance with terms and conditions or probation;
• To ensure the child's/youth's physical safety or the safety or others, e.g. suicide;
• To address conditions that are not part of the child's/youth's mental health condition.

If any of the above conditions are met, disallow that claim.

DHCS/ACBHCS Reason for Recoupment:
#20a - TBS cannot be provided for the convenience of the family, caregivers, physician, or teacher.
#20b - TBS cannot be used for purpose of client/youth supervision or to ensure compliance with terms and conditions of probation.
#20c - TBS cannot be provided for the purpose of ensuring the child's/youth's physical safety or the safety of others, e.g., suicide watch.
#20d - TBS cannot be provided to address conditions that are not a part of the child's/youth's mental health condition.

Percent Compliant

51. For each TBS claim during the audit period,TBS services wereNOT provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility? [% Compliant = TBS Claims in allowed locations/Total TBS claims]

Disallow TBS claims while client is in one of the above locations.

DHCS Reason for Recoupment #21:
TBS services are not allowed to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

Percent Compliant

52. Does the TBS Plan or Client Plan document the following:

Specific target behaviors or symptoms that are jeopardizing the current place of residence or presenting a barrier to transitions (e.g. temper tantrums, property destruction, and assaultive behavior in school)? [yes=100% no=0%]

DHCS/ACBHCS Reason for Recoupment (indicate all that apply):
#8b - No TBS Plan (or not within Client Plan).
#8c1 - TBS or Client Plan does not document specific target behaviors or symptoms that are jeopardizing the current place of residence or presenting a barrier to transitions (e.g. temper tantrums, property destruction, and assaultive behavior in school).

• If requirements not in TBS or Client Plan, disallow all TBS claims for plan period.

◯ 0 ◯ 100

53. Does the TBS Plan or Client Plan document the following:

Detailed interventions to resolve behaviors or symptoms, such as anger management techniques? [yes=100% no=0%]

DHCS/ACBHCS Reason for Recoupment (indicate all that apply):
#8b - No TBS Plan (or not within Client Plan).

• If requirements not in TBS or Client Plan, do not disallow and give quality feedback.

◯ 0 ◯ 100

54. Does the TBS Plan or Client Plan document the following:

Specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and has been replaced by adaptive behaviors? [yes=100% no=0%] If no, disallow all TBS claims for plan period.

DHCS/ACBHCS Reason for Recoupment (indicate all that apply):
#8b - No TBS Plan (or not within Client Plan).

• If requirements not in TBS or Client Plan, do not disallow and give quality feedback.

◯ 0 ◯ 100

55. Does the TBS Plan or Client Plan document the following:

A transition plan from the inception of TBS to decrease or discontinue TBS when these services are no longer needed or when the need to continue TBS appears to have reached a plateau in benefit effectiveness? [yes=100% no=0%]

NOTE: Review plan for evidence in the initial treatment plan of a timeline for reviewing the partial or complete attainment of behavioral benchmarks.

DHCS/ACBHCS Reason for Recoupment (indicate all that apply):
#8b - No TBS Plan (or not within Client Plan).

• If requirements not in TBS or Client Plan, do not disallow and give quality feedback.

◯ 0 ◯ 100

56. Does the TBS Plan or Client Plan document the following:

The manner for assisting parents/caregivers with skills and strategies to provide continuity of care when the service is discontinued? [yes=100% no=0%]

NOTE: Review plan for evidence in the initial treatment plan that describes how parents/caregivers will be assisted with skills and strategies to provide continuity of care when the service is discontinued or a timeline for developing how parents/caregivers will be assisted.
• When the beneficiary receiving TBS is not a minor (age 18 - 20), the transition plan would involve parents/caregivers or other significant support persons in the beneficiary's life only with appropriate consent from the beneficiary.

DHCS/ACBHCS Reason for Recoupment (indicate all that apply):
#8b - No TBS Plan (or not within Client Plan).

• If requirements not in TBS or Client Plan, do not disallow and give quality feedback.

◯ 0 ◯ 100

SPECIAL NEEDS QUESTIONS

57. The client's cultural and communication needs, or lack thereof, have been noted in the most recent required client plan/assessment? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

58. If identified, were cultural and communication needs addressed as appropriate? [yes=100% no=0% N/A=999] (Auditor to review most recent required client plan/assessment.)

◯ 0 ◯ 100 ◯ 999

59. The Client's physical limitations, or lack thereof, are noted in most recent required client plan/assessment? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

60. If identified, were physical limitations addressed as appropriate? [yes=100% no=0% N/A=999] (Auditor to review most recent required client plan/assessment.)

◯ 0 ◯ 100 ◯ 999

MEDICATION LOG, CONSENT, E/M SERVICES SKIP LOGIC

Is the client being prescribed medication(s) under the care of an MD/NP at this clinic? (auditor should choose yes if the client is under the care of an MD/NP at the clinic whether or not there are claimed med services for audit period)

- ○ Yes (answer Med. questions)
- ○ No (skip to Progress Notes)

MEDICATION LOG, MEDICATIONS CONSENTS, & E/M SERVICES QUESTIONS

If medications are prescribed use this section to evaluate compliance in logging medications. Logging may be found on a distinct section of the medical record or in the body of a progress note.

61. Med. log (or note) updated at each visit with date of Rx? [yes=100% no=0%]

◯ 0 ◯ 100

62. Med. log (or note) updated at each visit with drug name? [yes=100% no=0%]

◯ 0 ◯ 100

63. Med. log (or note) updated at each visit with drug strength/size? [yes=100% no=0%]

◯ 0 ◯ 100

64. Med. log (or note) updated at each visit with instruction/frequency of Rx? [yes=100% no=0%]

◯ 0 ◯ 100

65. Med. log (or note which requires signature) updated at each visit with prescriber's signature/initials? [yes=100% no=0%]

◯ 0 ◯ 100

66. Informed Consent for Medication(s) and JUV 220/3 (req's for foster children) are present when applicable? [Review all: # present/total required]

Percent Compliant

67. The informed consent form for medications explains each (not simply attestation): (1) Rx name, (2) specific dosage or range, (3) administration route, (4) expected uses/effects (reasons used), (5) short term and LT (beyond 3 mos.) risks/side effects, (6) available and reasonable alternative treatment, (7) duration of taking the medication, (8) consent once given may be withdrawn at any time, (9) client signature, (10) client name or ID, (11) prescriber signature, (12) indication that client was offered a copy of consent (for item #12 only, if the client speaks a threshold language, to receive credit for this item, the consent or related progress note contains a statement to indicate "the client was offered a copy of the consent in their threshold language" or a statement to indicate that the provider explained, or offered to explain the consent to the client in their threshold language, OR, there should be a copy of the consent in the client's threshold language). (Threshold languages: Spanish, Cantonese, Mandarin, Farsi, Vietnamese, Korean, Tagalog) [# compliant/12 or 8% for each item]

Percent Compliant

68. E/M progress notes are compliant with E/M documentation standards. [% audited claims compliant, N/A=999] If auditing to B(P)IRP standard only, choose 999.

Percent Compliant

PROGRESS NOTES QUESTIONS

69. There is a progress note (PN) for every service contact? [% audited claims compliant] (For Day Rehabilitation services a Weekly progress note is required)

DHCS reason for Recoupment:
#9 - No progress note was found for service claimed.

--Disallow corresponding claims for missing or incorrectly dated PNs.

Percent Compliant

70. Correct CPT #, InSyst #, ORexact procedure code name from *April 2016 ACBHCS InSyst Procedure Code Table*? [% audited claims compliant]

• Applies to claims where: 1) code is missing, 2) code does not match claims sheet, and/or 3) note content does not support code chosen.
• Score claims with missing PNs as deficient for this item.
• Disallow corresponding claims for deficient PNs above.

Exceptions:
• For collateral claims where a more specific collateral code should have been used, score as deficient and give a quality comment, but do not disallow.
• If Assessment code was used for Behavioral Evaluation service (with a non-integrated CANS/ANSA with Assessment), score as deficient and give a quality comment, but do not disallow.
• If face to face and non-face to face are used incorrectly/interchanged, bring to CRS to determine how to score.

DHCS reason for Recoupment:
#19a1 - SMHS Service claimed does not match type of SMHS Service documented.

Percent Compliant

71. Date of service indicated and correct? [% audited claims compliant] (For Day Rehabilitation services a Weekly progress note with corresponding dates of service is required)

• Score claims with missing PNs as deficient for this item.
• Disallow corresponding claims for deficient PNs.

DHCS reason for Recoupment:
#9 - No progress note was found for service claimed.

Percent Compliant

72. Location of service indicated and correct? [% audited claims compliant]
These codes or labels are the only allowed:

1 = Office
2 = Field
3 = Phone
4 = Home
5 = School
6 = Satellite
8 = Jail
9 = Inpatient
10 = Homeless Emergency Shelter
11 = Faith based/Church/Temple
12 = Health Care/Primary Care
13 = Age specific Comm Ctr
14 = Client's Job Site
15 = Res Care / Adult
16 = Mobile Services
17 = Non Traditional Serv
18 = Other Community Loc
19 = Res Care / Children
22 = Court

Score claims with missing PNs as deficient for this item. If wrong location designated, provide quality comment.

Percent Compliant

73. Face-to-Face Time and Total Time are both documented? [% of time based code PNs audited compliant, N/A=999] (Score N/A for Day Rehabilitation) (applies to all PNs for quality score)

- *When a service is provided on the telephone--the provider must indicate in the PN the amount of contact time on the phone. If the service provided was a time based code the claim is disallowed. If the service provided was not a time based code, don't disallow claim but give a quality comment. Score 0 for both instances.*
- Score claims with missing PNs as deficient for this item.
- Disallow corresponding claims for deficient PNs for time based codes only.

DHCS reason for recoupment:
#10d - The time claimed was greater than the time documented: Time on PN is not broken down into face-to-face and total time (for time based codes—crisis, ind. psychotherapy, E/M when > 50% of face-to-face time is spent as Counseling & Coordination of Care).

Percent compliant

74. Time documented on PN equals time claimed (not overbilled)? [% audited claims compliant]

- Score 999 for Day Rehabilitation.
- Score claims with missing PNs as deficient for this item.
- Disallow any overbilled claims.

DHCS reason for recoupment:
#10b The time claimed was greater than the time documented: Total time documented on PN does not equal time claimed (overbilled).

Percent Compliant

75. Time noted for documentation of service is reasonable? [% audited claims compliant] N/A=999]

- Score 999 for Day Rehabilitation.
- Score claims with missing PNs as deficient for this item.
- For claims where it is not possible to determine time spent doing documentation, score as 0 and make quality comment.
- If documentation time is 10 minutes or less, do not apply.Do not apply for group notes. Other possible exceptions: assessment, plan development, crisis services).
- Disallow related claims for any PNs which indicate >25% of total time is documentation time. e.g., Total time = 60 minutes and Doc time > 15 minutes (15/60=25%)

DHCS reason for recoupment:
#10c - The time claimed was greater than the time documented: Written documentation does not support documentation time claimed or documentation time is excessive (Documentation time > 25% of total time).

Percent Compliant

76. Documentation content supports amount of direct service time claimed? [% audited claims compliant]

• Score claims with missing PNs as deficient for this item.
• Disallow corresponding claims for deficient PNs.

DHCS reason for Recoupment:
#10a - The time claimed was greater than the time documented: Documentation content does not support amount of service time claimed.

Percent Compliant

77. PN includes a description of that day's presenting problem/evaluation/behavioral presentation or purpose of service? [% audited claims compliant]

Score claims with missing PNs as deficient for this item.

Percent Compliant

78. PN includes a staff Specialty Mental Health Service intervention component? [% audited claims compliant]

• Score claims with missing PNs as deficient for this item (for quality scoring purposes)(Claim was disallowed under question # 69.)
• Disallow corresponding claims for deficient PNs.
• Progress notes that claim additional time for Co-staff must document the co-staff clinician's interventions as well as the primary clinician's interventions. If either staff's interventions are missing, the claim is disallowed.

DHCS reason for Recoupment (choose one):
No service was provided:
#19a2b - PN does not include: Staff's Mental Health Intervention for the date of service.
#19a3 - PN extensive cut & paste activity for: Staff's Intervention, OR Client's Response to Staff Intervention.
#19a6a - Service is a Non-MH one.
#19a7 - Illegible Progress Note (to degree—no actual content for Intervention/Response component).

Percent Compliant

79. PN includes a description of that day's client response to interventions? (or response from others involved in client treatment if collaterals, brokerage providers, etc.) [% audited claims compliant]

• Score claims with missing PNs as deficient for this item (for quality scoring purposes)(Claim was disallowed under question # 69.)
• Disallow corresponding claims for deficient PNs.

DHCS Reason For Recoupment:
#19a2c - PN does not include: Client's Response to that day's Staff Intervention.

Percent Compliant

80. PN includes a description of client's and/or staff's plan/follow-up including referrals to community resources and other agencies and any follow up care when appropriate? [% audited claims compliant]

Score claims with missing PNs as deficient for this item. (for quality scoring purposes)(Claim was disallowed under question # 69.)

Percent Compliant

81. Claimed service is NOT a planned service provided before the Initial Client plan due date that does not have *medical and service necessity* documented in the completed mental health assessment? [% compliant audited claims].

Disallow any claims for planned services before Initial Client Plan is completed that do not meet above requirements.

Planned Services

- Collateral (requirement pending)
- Case Management
- Medication Services
- Individual Therapy
- Individual Rehabilitation
- Group Therapy
- Group Rehabilitation
- Family Therapy (Includes Single Family and Multi-Family Group)
- TBS
- Katie A (ICC, and/or IHBS)
- Day Rehabilitation (1/2 or Full Day)
- Psychological Testing (Includes Psych Test, Developmental & Neuropsych)
- Residential (Includes Adult and Crisis)

Services not required to be in Plan

- Assessment (includes w/ and w/o medical & CANS/ANSA)
- Plan Development
- Crisis Therapy & Crisis Stabilization
- Interactive Complexity
- Collateral (for now)

DHCS reason for Recoupment:

#5a - A planned SMHS is provided before the Initial Client Plan due date, and medical and service necessity for the planned service is not documented in the completed mental health assessment.

Percent Compliant

82. If a Group Service PN, the time is calculated correctly and the # of clients served is included in the note? [% audited claims compliant] N/A=999] (Score N/A for Day Rehabilitation).

• Score claims with missing PNs as deficient for this item (for quality scoring purposes)(Claim was disallowed under question # 69.)
• Disallow corresponding claims for deficient PNs.

DHCS reason for Recoupment (include all that apply):
#14a - Group service note does not include # of clients served (Time claimed calculation may be correct or incorrect).
#14b - Group service note does not include # of staff present (Time claimed calculation may be correct or incorrect).
#14c - Time claimed is inaccurately calculated (due to reason not listed above).

Percent Compliant

83. Services are related to current mental health objectives listed in Client Plan? [% audited claims compliant] N/A=999] (choose N/A if there are no planned services or if there is no client plan and the provider is claiming for planned services based on medical necessity established in the assessment).

• Score claims with missing PNs as deficient for this item (for quality scoring purposes)(Claim was disallowed under question # 69.)
• Disallow corresponding claims for deficient PNs.

DHCS reason for Recoupment:
19a2a - Service being addressed the day of M/C claim is associated with an existing (current - not expired) MH Objective in the Client Plan

Percent Compliant

84. Unresolved issues from prior services addressed, if applicable? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

85. PN is signed? [% audited claims compliant]

• Score claims with missing PNs as deficient for this item.
• Disallow corresponding claims for deficient PNs.

DHCS reason for recoupment (include all that apply):
#15a - Missing service provider signature.
#15b - Missing required LPHA co-signature (Licensed LPHA required for trainees and for others as required by the agency).

Percent Compliant

86. PN signature is dated? [% audited claims compliant]

Score claims with missing PNs as deficient for this item.

Percent Compliant

87. PN signature or printed name contains Medi-Cal designation: Licensed/registered/waivered/MHRS/Adjunct? [% audited claims compliant]

Score claims with missing PNs as deficient for this item.

Percent Compliant

88. Completion line after signature (N/A If EHR notes)? [% audited claims compliant; N/A=999]

Score claims with missing PNs as deficient for this item.

Percent Compliant

89. Service provided while client was NOT in a lock-out (ie. IMD, jail, etc)? [% audited claims compliant]

Lockout Matrix provided below, disallow all services claimed during lockout situations. For IMD lockouts, use the lockout matrix and use link to the list of IMD facilities <-(hyperlink) provided by DHCS.

DHCS reason for Recoupment #11

Percent Compliant

Lockout Situations

Lockout Situations: A "lockout" means that a service activity is not reimbursable through Medi-Cal because: the beneficiary resides in and/or receives mental health services in one of the settings listed below Or regulation provides a maximum allowable claimable time for a SMHS. (*A staff may provide services within their scope of practice, but it would not be reimbursable.)*

Find Type of Service You Want to Provide → **Then Look at Service Site or Claimable Time for SMHS to Find Restrictions (if any)** ↓	**Locked out for MH Svcs (includes IHBS)?** ***NOTE:* GREEN =**	**Locked out For Medication Svcs?** *NO LOCKOUT **AND** RED*	**Locked out for C/M Brokerage Svcs (includes ICC)?** *= LOCKOUT*
Woodroe Place, Jay Mahler Recovery Center, Amber House (Crisis Residential Treatment)	MH svcs locked out (1) *except day of admit & d/c*	Med Svcs not locked out	C/M Svcs not locked out
Sausal Creek, Willow Rock CSU (Crisis Stabilization)	MH Svcs not locked out (2) *except during same time period of CSU*	Med Svcs not locked out (2) *except during same time period of CSU*	C/M Svcs not locked out
Day Rehab Programs & Day Treatment Intensive Programs	MH Svcs not locked out (2) *except during same time period of Day Pgm*	Med Svcs not locked out (2) *except during same time period of Day Pgm*	C/M Svcs not locked out (2) *except during same time period of Day Pgm*
Juvenile Hall, Jail or Similar Detention (not adjudicated)	MH Svcs locked out (1) *except day of admit & d/c OR (3) if minor adjudicated (release order) awaiting placement*	Med svcs locked out (1) *except day of admit & d/c OR (3) if minor adjudicated (release order) awaiting placement*	C/M Svcs locked out (1) *except day of admit & d/c OR (3) if minor adjudicated (release order) awaiting placement*
Willow Rock PHF (Acute Psychiatric Inpatient Hospital/PHF for minors),	MH svcs locked out (1) *except day of admit & d/c*	Med Svcs locked out (1) *except day of admit & d/c*	C/M Svcs locked out (1) *except day of admit & d/c OR (4) 30 days prior to planned d/c for placement purposes*
John George Psychiatric Pavilion (SD/MC Hospital), **Alta-Bates Herrick** (FFS Hospital) (Non-Free Standing Acute Psychiatric Inpatient Hospital)	MH svcs locked out (1) *except day of admit & d/c*	Med Svcs locked out (1) *except day of admit & d/c*	C/M Svcs locked out (1) *except day of admit & d/c OR (4) 30 days prior to planned d/c for placement purposes*

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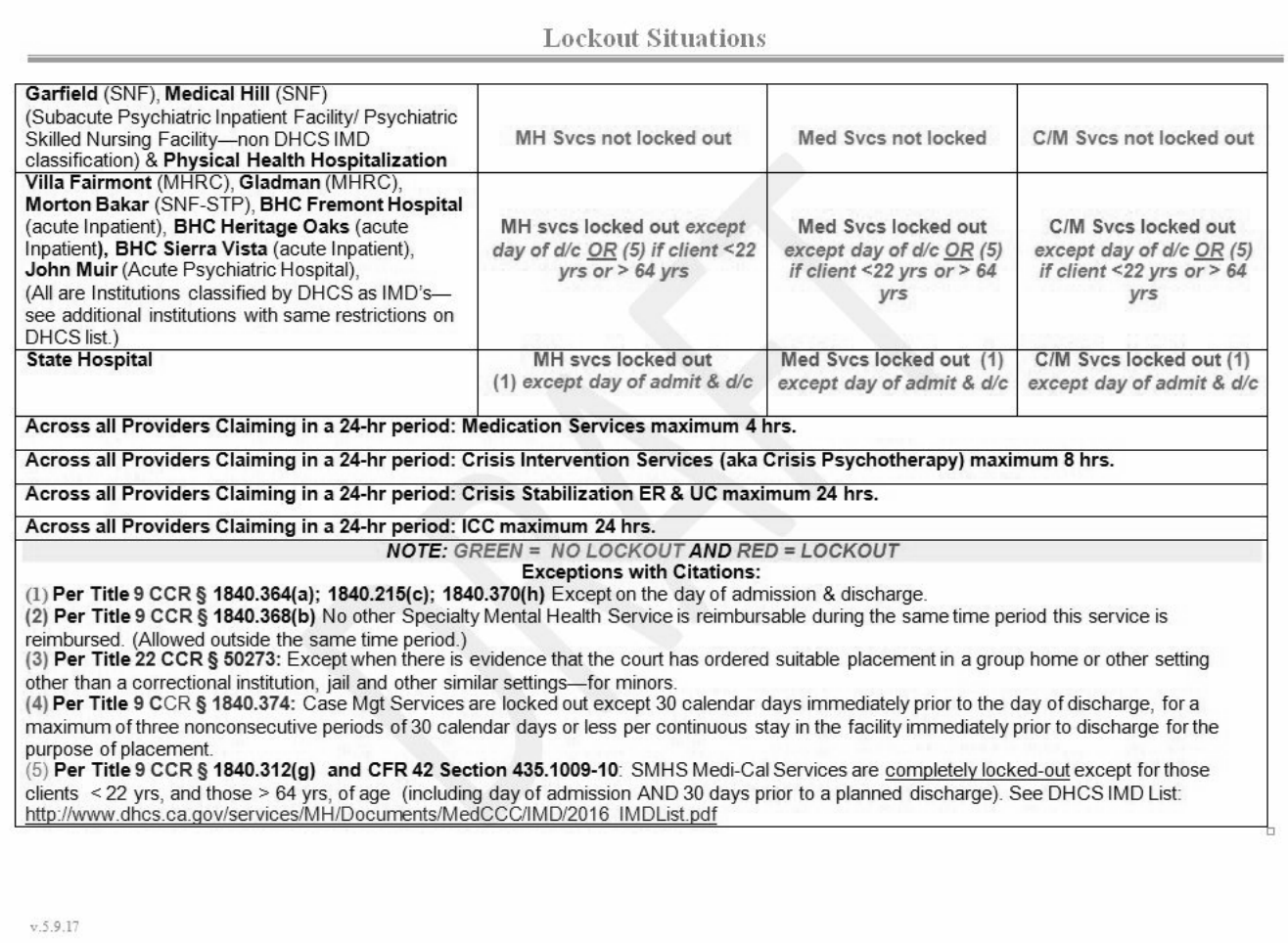

Lockout Situations

Garfield (SNF), **Medical Hill** (SNF) (Subacute Psychiatric Inpatient Facility/ Psychiatric Skilled Nursing Facility—non DHCS IMD classification) & **Physical Health Hospitalization**	MH Svcs not locked out	Med Svcs not locked	C/M Svcs not locked out
Villa Fairmont (MHRC), **Gladman** (MHRC), **Morton Bakar** (SNF-STP), **BHC Fremont Hospital** (acute Inpatient), **BHC Heritage Oaks** (acute Inpatient), **BHC Sierra Vista** (acute Inpatient), **John Muir** (Acute Psychiatric Hospital), (All are Institutions classified by DHCS as IMD's—see additional institutions with same restrictions on DHCS list.)	MH svcs locked out *except day of d/c OR (5) if client <22 yrs or > 64 yrs*	Med Svcs locked out *except day of d/c OR (5) if client <22 yrs or > 64 yrs*	C/M Svcs locked out *except day of d/c OR (5) if client <22 yrs or > 64 yrs*
State Hospital	MH svcs locked out (1) *except day of admit & d/c*	Med Svcs locked out (1) *except day of admit & d/c*	C/M Svcs locked out (1) *except day of admit & d/c*
Across all Providers Claiming in a 24-hr period: Medication Services maximum 4 hrs.			
Across all Providers Claiming in a 24-hr period: Crisis Intervention Services (aka Crisis Psychotherapy) maximum 8 hrs.			
Across all Providers Claiming in a 24-hr period: Crisis Stabilization ER & UC maximum 24 hrs.			
Across all Providers Claiming in a 24-hr period: ICC maximum 24 hrs.			

***NOTE:** GREEN = NO LOCKOUT **AND** RED = LOCKOUT*

Exceptions with Citations:

(1) **Per Title 9 CCR § 1840.364(a); 1840.215(c); 1840.370(h)** Except on the day of admission & discharge.
(2) **Per Title 9 CCR § 1840.368(b)** No other Specialty Mental Health Service is reimbursable during the same time period this service is reimbursed. (Allowed outside the same time period.)
(3) **Per Title 22 CCR § 50273:** Except when there is evidence that the court has ordered suitable placement in a group home or other setting other than a correctional institution, jail and other similar settings—for minors.
(4) **Per Title 9 CCR § 1840.374:** Case Mgt Services are locked out except 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement.
(5) **Per Title 9 CCR § 1840.312(g) and CFR 42 Section 435.1009-10**: SMHS Medi-Cal Services are completely locked-out except for those clients < 22 yrs, and those > 64 yrs, of age (including day of admission AND 30 days prior to a planned discharge). See DHCS IMD List: http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/IMD/2016_IMDList.pdf

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90. Service provided while client was NOT in juvenile hall? [% audited claims compliant]

Disallow claims for all dates of service after admission day unless the exception criteria is met.Use provided Lockout Matrix for reference.

DHCS reason for recoupment #12

Percent Compliant

91. Service provided was NOT for academic educational svc, vocational svc, recreation and/or socialization? [% audited claims compliant]

Disallow corresponding claims for any PNs indicating above services.

DHCS reason for recoupment:

#13a - Non- billable service – educational related (solely or in part without time apportioned).
#13b - Non- billable service – vocational related (solely or in part without time apportioned).
#13c - Non- billable service – recreational related (solely or in part without time apportioned).
#13d - Non- billable service – social group related (solely or in part without time apportioned).

Percent Compliant

92. Service provided was NOT transportation related? [% audited claims compliant]

Disallow corresponding claims for any PNs indicating service was transportation activity.

DHCS reason for recoupment:

#16 - Non- billable activity – transportation related (solely or in part without time apportioned).

Percent Compliant

93. Service provided was NOT clerical related? [% audited claims compliant]

Disallow corresponding claims for any PNs indicating above services

DHCS reason for recoupment:

#17a - Non- billable electronic-type activity – voicemail/email/text/IM, etc. (solely or in part without time apportioned).
#17b - Non- billable activity – scheduling appointment related (solely or in part without time apportioned).
#17c - Non- billable activity – Other clerical/administrative related (solely or in part without time apportioned).

Percent Compliant

94. The service was NOT payee related? [% audited claims compliant]

Disallow corresponding claims for any PNs indicating payee related services

DHCS reason for recoupment:

#18 - Non- billable activity – payee related (solely or in part without time apportioned).

Percent Compliant

95. The case was open to the provider at the time of service? [% audited claims compliant]

Disallow corresponding claims for services after case closed.

DHCS reason for recoupment:
#19a4 - No service was provided: Case closed, cannot bill

Percent Compliant

96. The client was NOT deceased at the time of service? [% audited claims compliant]

Disallow corresponding claims for services after client deceased

DHCS reason for recoupment:
#19a5 - No service was provided: Client deceased, cannot bill

Percent Compliant

97. The service was NOT a non-billable Activity for Completion of ACBHCS Screening Tool? [% audited claims compliant]

Disallow corresponding claims for PNs indicating above service

DHCS reason for recoupment:
#19a6a - No service was provided: Non SMHS Service Intervention: Service is a Non-MH one.

Percent Compliant

98. The PN does NOT indicate a duplication of service? [% audited claims compliant]

Disallow corresponding claims for duplicated services

DHCS reason for recoupment (include all that apply):
No service was provided:
#19a8a - Duplication of services: Same service billed twice by same provider.
#19a8b - Duplication of services: Same service by different providers without documentation to support co-staffing.

Percent Compliant

99. The service was NOT supervision related? [% audited claims compliant]

Disallow corresponding claims for PNs indicating the service was supervision related

DHCS reason for recoupment:
#19a9 - No service was provided: Non- billable activity – supervision related (no claiming for speaking with supervisors).

Percent Compliant

100. If the PN documents a discharge note/summary, it is only billed as part of a billable service with the client present OR it contains activity for referral purposes? [% audited claims compliant; N/A=999]

Disallow corresponding claims for PNs which do no meet above criteria

DHCS reason for recoupment:
#19a6a - No service was provided: Non SMHS Service Intervention: Service is a Non-MH one.

Percent Compliant

101. The PN was finalized within (5) five business days? [% audited claims compliant]

Percent Compliant

102. If the PN is late, "late note" is indicated in the body of the PN? [% late PNs audited claims compliant, N/A=999]

Percent Compliant

103. Claimed service was (solely or without time apportioned) for housing support without justification for C/M? [% audited claims compliant].

Disallow claims for housing support related services.

DHCS reason for recoupment:
#19a14 - No service was provided: Non-billable activity - housing support related (solely or in part without time apportioned).

Percent Compliant

104. The claimed service was NOT for a No Show activity? [% audited claims compliant]

Disallow corresponding claims for no show activities.

DHCS reason for recoupment:
#19a15 - Non-billable activity - No show

Percent Compliant

105. The claimed service was NOT for a non-therapeutic mandated reporting activity (written and/or telephone CPS/APS report)? [% audited claims compliant]

Note: If mandated reporting is documented in a PN, any time spent on the reporting process can not be claimed and must be clearly apportioned (not billed). Mandated reporting activities can be claimed if provided as a SMHS intervention with client or caregivers present. The clinical justification and intervention must be clearly documented in the PN.

Disallow claims that do not apportion non-therapeutic mandated reporting time as non-billable.

DHCS reason for Recoupment:
#19a16 - Non-billable activity - Non-therapeutic mandated reporting - written and/or telephone (CPS/APS) (solely or in part without time apportioned).

Percent Compliant

106. Claimed service (solely or in part without time apportioned) was NOT for writing non-mandated CPS/CPS reports for non-clinical treatment purposes (SSI, CFS, etc.)? [% audited claims compliant]

Disallow claims that do not apportion time for non-clinical report writing as non-billable.

DHCS reason for Recoupment:
#19a17 - Writing reports for non-clinical treatment purposes (SSI, CFS, Court Document, etc) (solely or in part without time apportioned).

Percent Compliant

107. Claimed service was NOT interpretation related (solely or in part)? [% audited claims compliant]

If staff is interpreting, no other services may be claimed by that person. Disallow any claims that are solely or in part for interpretation activities.

DHCS reason for Recoupment:
#19a18 - Non-billable activity - Interpretation related (solely or in part). If staff is interpreting, no other services may be claimed by that person.

Percent Compliant

108. Claimed service was NOT for a review of medical records without clinical justification and/or documentation of relevant content found? [% audited claims compliant]

Disallow any claims for medical record reviews that do not have<u>both</u> clinical justification and documentation of relevant content found.

<u>DHCS reason for Recoupment:</u>
#19a19 - Review of medical records without clinical justification and/or documentation of relevant content found.

Percent Compliant

109. Progress note documents the language that the service is provided in (or note in Assessment that client is English-speaking & all services to be provided in English)? [% audited claims compliant]

Percent Compliant

110. Progress note indicates interpreter services were used, and relationship to client is indicated, if applicable? [% audited claims compliant, N/A=999]

Percent Compliant

111. Service was provided within the scope of practice of the person delivering the service? [% audited claims compliant]

Disallow corresponding claims for PNs that indicate staff was not within their scope of practice

<u>DHCS reason for recoupment #19d</u>

Percent Compliant

112. What is the percent of compliant C/M types provided? [%=Total compliant types of C/M services/Total number of identified C/M types/needs; N/A=999] (stratify per each type of C/M needed; e.g. If housing C/M claiming is fully compliant but medical is not, then score 50%).

MH C/M types can include: housing, economic, vocational, educational, medical needs, SUD, etc)

• For all three below, if identified in assessment or treatment plan then does not need to be repeated in every PN.
• If any of the three are not in the assessment or plan, those must be in every progress note.

For each type of C/M service claimed:

1. Is the specific area of C/M indicated as a need?
2. Is it indicated that C/M need is due to (a or b):

a) 18+ y/o does the included diagnosis(es)' symptoms and/or impairments prevent client from accessing needed community supports?

b) <18 y/o are client's included diagnosis(es)' symptoms and/or impairments exacerbated by C/M need? (homelessness, medical not addressed, SUD, etc.)

3. Is it indicated that successful C/M in the area of need will result in client's symptoms of included diagnosis being decreased or eliminated (or MH objectives obtained)?

Disallow claims that do not meet one or more of the C/M requirements

DHCS reason for recoupment:
Services do not meet requirements for C/M claiming (If any one of a-c are not in the Assessment or Client Plan – they must be documented in every C/M note):
#19a20a - Area of C/M need is not indicated in Assessment, Client Plan, or Progress Note(s) as required.
#19a20b - Medical need for C/M is not supported in Assessment, Client Plan, or Progress Note(s) as required: Record indicates for clients ≥18 years – symptoms/impairments of Included Diagnosis prevent client from utilizing community supports in C/M area of need OR for clients <18 years, area of need (housing, medical, educational, SUD, etc.) exacerbates client's symptoms/impairments of Included Diagnosis.
#19a20c - Service need for C/M is not supported in Assessment, Client Plan, or Progress Note(s) as required: Record indicates successful result of C/M services (now housed, receiving medical care, etc.) will decrease client's symptoms/impairments of Included Diagnosis).

Percent Compliant

CHART MAINTENANCE QUESTIONS

113. Admission date is noted correctly? (EOD noted in chart should match InSyst) [yes=100% no=0%]

◯ 0 ◯ 100

114. Emergency contact info in designated location in file/EHR AND at a minimum on the InSyst Face Sheet as Emergency Contact?
Item is out of compliance if not on InSyst Face Sheet asemergency contact.
If on InSyst Face Sheet, but not in designated location in paper/EHR file--Quality Comment only.
[yes=100% no=0%]

◯ 0 ◯ 100

115. Releases of Information (ROI) *(< 12 months old - or less if so indicated),*when applicable? [Review all: # present/total required]

Note: Not required for communication between ACBHCS or ACBHCS contracted health and mental health providers. If out of compliance--recommend that annually at EOD all releases are re-done.

Percent Compliant

116. Writing is legible? [# of areas compliant/areas applicable] (Auditor to review all hand written documents in 5 areas: Assessments, Client Plans, non-clinical forms, PN's, and MD documents)

Percent Compliant

117. Signatures are legible (or printed name under signature or signature sheet)? [# of areas compliant/areas applicable] (Auditor to review all signed documents in 5 areas: Assessments, Client Plans, non-clinical forms, PN's, MD documents)

.Percent Compliant

118. When done, service-related client (personal) correspondence is provided in the client's preferred language? [N/A=999]

Percent Compliant

119. When indicated, treatment specific information is provided to the client in an alternative format (e.g., braille, audio, large print, etc)? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

120. Filing is done appropriately? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

121. Client identification is present on each page in the clinical record? [# of areas compliant/areas applicable] (Auditor to review all documents in 5 areas: Assessment, Client Plans, non-clinical forms, PN's, MD documents)

Percent Compliant

122. If the client has been discharged, the date indicated in the discharge note/summary matches the date in InSyst.? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

123. The documentation in the chart does not contain significant cut and paste activity? [# of areas compliant/areas applicable] (Auditor to review all documents in 5 areas: Assessment, Client Plans, non-clinical forms, PN's, MD documents)

Percent Compliant

124.The documentation in the chart uses only county-designated acronyms and abbreviations? [yes=100% no=0%]

◯ 0 ◯ 100

Is this a chart for Day Rehabilitation / Day Treatment Intensive services?

◯ Yes (Answer Day Rehab/DTI questions)

◯ No (Site Compliance Skip Logic)

DAY REHABILITATION (DR) / DAY TREATMENT INTENSIVE (DTI) QUESTIONS

125. Do *all* of the *Written Weekly Schedules* for the audit period show that a community meeting has occurred at least once a day? [yes=100% no=0%] (Review *all Written Weekly Schedules* for the audit period)

Definition: Community meetings address issues pertaining to the continuity and effectiveness of the therapeutic milieu, and shall actively involve staff and clients. Relevant discussion items include, but are not limited to: the day's schedule, any current event, individual issues that staff or client wish to discuss to elicit support of the group and conflict resolution

DHCS reason for recoupment:
#19a10 - Day Rehabilitation / Day Treatment Intensive did not include all the required service components.

--Disallow any claims until criteria is met

◯ 0 ◯ 100

126. Do all of the *Written Weekly Schedules* for the audit period show that the community meeting included a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker or marriage and family therapist; or a registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist? [yes=100% no=0%] (Review Written Weekly Schedule)

DHCS reason for recoupment:
#19a10 - Day Rehabilitation / Day Treatment Intensive did not include all the required service components.

--Disallow any claims until criteria is met

◯ 0 ◯ 100

127. Do all of the *Written Weekly Schedules* for the audit period show that the therapeutic milieu includes Process Groups? [yes=100 no=0%] (Review Written Weekly Schedule) (Day Rehabilitation may include psychotherapy instead of process groups, or in addition to process groups; DTI must have psychotherapy AND process groups - brion to verify if accurate)

Definition: Process Groups shall assist each client to develop necessary skills to deal with his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems.

DHCS reason for recoupment:
#19a10 - Day Rehabilitation / Day Treatment Intensive did not include all the required service components.

--Disallow any claims until criteria is met

◯ 0 ◯ 100

128. Do all of the *Written Weekly Schedules* for the audit period show that the therapeutic milieu includes Skill Building Groups? [yes=100% no=0%] (Review Written Weekly Schedule)

Definition: Skill Building Groups - staff shall help clients identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, clients identify skills that address symptoms and increase adaptive behaviors.

DHCS reason for recoupment:
#19a10 - Day Rehabilitation / Day Treatment Intensive did not include all the required service components.

--Disallow any claims until criteria is met

◯ 0 ◯ 100

129. Do all of the *Written Weekly Schedules* for the audit period show that the therapeutic milieu includes Adjunctive Therapies? [yes=100% no=0%] (Review Written Weekly Schedule)

Definition: Adjunctive Therapies - these are therapies in which both staff and clients participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Clients do not need a skill level, but rather should be able to utilize the modality to develop or enhance skills directed toward achieving client plan goals. The therapies should assist the client in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehab are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the client's needs identified in the client plan.

DHCS reason for recoupment:
#19a10 - Day Rehabilitation / Day Treatment Intensive did not include all the required service components.

--Disallow any claims until criteria is met

◯ 0 ◯ 100

130. Does the documentation show the total number of minutes/hours the client attended the program? [yes=100% no=0%] *(Daily or Weekly PN's must indicate daily time attended in program by hours and minutes. If in both--must match. Also, compare PN time present which must match group and day sign-in sheets.)*

DHCS reason for recoupment:
#19a11 - The total number of minutes/hours the client actually attended Day Rehabilitation / Day Treatment Intensive were not documented.

--Disallow related claims for PNs that do not document above requirement

◯ 0 ◯ 100

131. If the client is unavoidably absent, does the documentation show the total time (number of hours and minutes) the client actually attended the program that day? [yes=100% no=0% N/A=999] (Review Progress Notes or Client Attendance Log in client record)

DHCS reason for recoupment:
#19a12 - The client did not receive the minimum required hours in order to claim for full or half Day Rehabilitation / Day Treatment Intensive services.

--Disallow related claims for PNs that do not document above requirement

◯ 0 ◯ 100 ◯ 999

132. If the client is unavoidably absent, does the documentation show that the client was present for at least 50 percent of the scheduled hours of operation for that day? [yes=100% no=0% N/A=999] (Review Progress Notes or Client Attendance Log in client record)

DHCS reason for recoupment:
#19a12 -The client did not receive the minimum required hours in order to claim for full or half Day Rehabilitation / Day Treatment Intensive services.

--Disallow related claims for PNs that do not document above requirement

◯ 0 ◯ 100 ◯ 999

133. If the client is unavoidably absent, is there a separate entry in the record documenting the reason for the unavoidable absence? [yes=100% no=0% N/A=999] (Review Progress Notes)

DHCS reason for recoupment:
#19a12 - The client did not receive the minimum required hours in order to claim for full or half Day Rehabilitation / Day Treatment Intensive services.

--Disallow all related claims until criteria met

◯ 0 ◯ 100 ◯ 999

134. If absences are frequent, does the documentation show that the provider has re-evaluated the client's need for Day Rehabilitation/DTI and has taken appropriate action? [yes=100% no=0% N/A=999] (Review Progress Notes)

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow any claims until criteria is met

◯ 0 ◯ 100 ◯ 999

135. Does the documentation show that there was at least one contact per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a minor client, that focuses on the role of the support person in supporting the client's community reintegration; and that this contact occurred outside the hours of operation? [yes=100% no=0%] (Review Progress Notes)
Note: This contact may be face-to-face or by email, phone, etc. Adult clients may decline this component.

Brion to verify this one for accuracy

DHCS reason for recoupment:
#19a10 - Day Rehabilitation / Day Treatment Intensive did not include all the required service components.

--Disallow any claims until criteria is met

◯ 0 ◯ 100 ◯ 999

136. Does the documentation for the audit period show for Half Day: the client received face-to-face services a minimum of three (3) CONTINUOUS hours each day the program was open; or for Full Day: the client received CONTINUOUS face-to-face services in a program with services available more than four (4) hours per day? [yes=100% no=0%] (Review Written Weekly Schedule, Daily Sign-in sheets, and Progress Notes to ensure this requirement is met)
Note: Breaks between activities, as well as lunch and dinner breaks, do not count toward the total continuous hours of operation for purposes of determining minimum hours of service. *Non DR Activities/groups cannot break up the continuous hours.*

DHCS reason for recoupment:
#19a12 - The client did not receive the minimum required hours in order to claim for full or half Day Rehabilitation / Day Treatment Intensive services.

--Disallow all related claims for services that do not meet above criteria

◯ 0 ◯ 100

137. Does the documentation for the audit period show there is at least one staff person present and available to the group in the therapeutic milieu? [yes=100% no=0%] (Review the Written Weekly Schedule to determine if the required and qualified staff were available for all scheduled hours of operation)

DHCS reason for recoupment:
#19a10 - Day Rehabilitation / Day Treatment Intensive did not include all the required service components.

--Disallow all related claims if criteria not met

◯ 0 ◯ 100

138. Does the documentation for the audit period show there is at least one staff (MHRS or above) to every ten clients in attendance or two staff to more than 12 clients attending during the period the program is open? [yes=100% no=0%] (Review Written Weekly Schedule and Daily Sign-in sheets)

Brion to verify for accuracy DR staffing and DTI staffing requirements

DHCS reason for recoupment:
#19a10 - Day Rehabilitation / Day Treatment Intensive did not include all the required service components.

--Disallow all related claims until criteria met

◯ 0 ◯ 100

139. Is there a Written Program Description which describes the specific activities of each service and reflects each of the required components of the services? [yes=100% no=0%] (Review Written Program Description and Written Weekly Schedule)

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow any claims until criteria is met

◯ 0 ◯ 100

140. Is there a Written Weekly Schedule for the audit period which identifies when and where the service components will be provided and by whom? [yes=100% no=0%]

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow any claims until criteria is met

◯ 0 ◯ 100

141. Does the Written Weekly Schedule for the audit period list the program staff, their qualifications, and the scope of their services? [yes=100% no=0%]

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow any claims until criteria is met

◯ 0 ◯ 100

142. If the Provider uses staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), is there documentation for the audit period of the scope of responsibilities for these staff and the specific times in which Day Rehabilitation/DTI activities are being performed exclusive of other activities? [yes=100% no=0% N/A=999]

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow any claims until criteria is met

◯ 0 ◯ 100 ◯ 999

143. Is there a Mental Health Crisis Protocol? [yes=100% no=0%]

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow any claims until criteria is met

◯ 0 ◯ 100

144. Does the documentation show that services were authorized in advance if provided more than five days per week? [yes=100% no=0% N/A=999] (review authorization form)

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow any claims until criteria is met

◯ 0 ◯ 100 ◯ 999

145. Does the documentation show that services were authorized for continuation - at least every 6 months for Day Rehab & at least every 3 months for DTI? [yes=100% no=0% N/A=999] (review authorization form)

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow any claims until criteria is met

◯ 0 ◯ 100 ◯ 999

146. Does the documentation show that the provider requested authorization for mental health services *(i.e. Med Support Svcs)* provided concurrently with Day Rehabilitation/DTI, excluding services to treat emergency and urgent conditions? [yes=100% no=0% N/A=999] (review authorization form)

DHCS reason for recoupment:
#19a13 - Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).

--Disallow all related claims until criteria met

◯ 0 ◯ 100 ◯ 999

Is this a site review case?

◯ Yes ◯ No

PES / CRISIS STABILIZATION PROGRAM QUESTIONS

Assessment / Diagnosis

147. Was the DSM-5 / ICD-10 Diagnosis done by staff allowable by DHCS (Registered/Waivered LPHA with LPHA co-signature or LPHA)? [yes=100% no =0%]

- If no, disallow all claims

DHCS Reason for Recoupment:
#1f - Diagnosis is not established by licensed LPHA OR not co-signed by licensed LPHA if established by a waivered staff or registered intern.

◯ 0 ◯ 100

148. Did the admitting diagnosis meet Medical Necessity; was a primary Included (Outpatient) M/C diagnosis established? [yes=100% no=0% N/A=999]

- If no, disallow all services.

DHCS Reason for Recoupment:
#1d - Non-Included Diagnosis
#1e - Documentation in the Assessment does not support the included diagnosis. (DSM Diagnostic Criteria is not met, or adequately documented, for a M/C Included Diagnosis.)

◯ 0 ◯ 100 ◯ 999

149. Did the documentation include the patient's presenting problems, symptoms and behaviors that prompted the Crisis Stabilization Unit (CSU) admission? [yes=100% no=0% N/A=999]

- If no disallow all services.

DHCS reason for Recoupment #2:
• Documentation does not support the impairment criteria; OR
• The condition can be treated in a physical health care based setting only.

◯ 0 ◯ 100 ◯ 999

150. Does the client record indicate client's legal status (Voluntary, 5150, Conserved)?[yes=100% no=0%]

If no, disallow all services.

DHCS reason for Recoupment:
#TBD

◯ 0 ◯ 100

151. Was a mental health crisis assessment completed, documenting current presenting mental health symptoms and medical necessity for crisis stay? [yes=100% no=0% N/A=999]

If no, disallow all services.

DHCS reason for Recoupment #2:
• Documentation does not support the impairment criteria; OR
• The condition can be treated in a physical health care based setting only.

◯ 0 ◯ 100 ◯ 999

152. Was a current risk assessment completed? [yes=100% no=0% N/A=999]

If no, give quality feedback.

◯ 0 ◯ 100 ◯ 999

153. Was a MSE (mental status exam) completed by allowable Licensed LPHA or Waivered/Registered LPHA with Licensed LPHA co-signature? [yes=100% no=0% N/A=999]

If no, disallow all services.

DHCS reason for Recoupment:
#1e - Documentation in the Assessment does not support the included diagnosis. (DSM Diagnostic Criteria is not met, or adequately documented, for a M/C Included Diagnosis.)
#1f - Diagnosis is not established by licensed LPHA OR not co-signed by licensed LPHA if established by a waivered staff or registered intern.

◯ 0 ◯ 100 ◯ 999

154. Was a physical health evaluation done by RN, LVN, LPT? [yes=100% no=0% N/A=999]

If no, disallow all services.

DHCS reason for Recoupment #2:
• Documentation does not support the impairment criteria; OR
• The condition can be treated in a physical health care based setting only.

◯ 0 ◯ 100 ◯ 999

155. If drug and/or alcohol issues are significant factors of 5150, was it addressed (treatment and/or referral)? [yes=100% no=0%]

If no, give quality comment.

◯ 0 ◯ 100

156. If outside services were needed, was a referral made to the extent of available resource(s)? [yes=100% no=0% N/A=999]

If no, provide quality comment.

◯ 0 ◯ 100 ◯ 999

157. If the patient was evaluated as needing service activities that could only be provided by a specific type of licensed professional, was such a person available? [yes=100% no=0% N/A=999]

If no, provide quality comment.

◯ 0 ◯ 100 ◯ 999

Medical Necessity

158. Was it documented that the client was a danger to self, others, or gravely disabled resulting from a mental disorder? [yes=100% no=0% N/A=999]

If no, disallow all services.

DHCS reason for Recoupment #2:
• Documentation does not support the impairment criteria; OR
• The condition can be treated in a physical health care based setting only.

◯ 0 ◯ 100 ◯ 999

159. If service was claimed it was at least 2 hours ? [Yes=100%, No=0%]

If less than two (2) hours of client contact, disallow claim.

Reason For Recoupment:
#10b - Total time documented on PN does not equal time claimed (overbilled)

◯ 0 ◯ 100

160. N/A=999

◯ 0 ◯ 100 ◯ 999

161. At discharge was client stabilized or referred to an appropriate level of care (e.g. Acute Inpatient, or CSU)? [yes=100% no=0% N/A=999]

If no, disallow all claims.

DHCS Reason For Recoupment:
#TBD2

◯ 0 ◯ 100 ◯ 999

162. Was discharge planning completed and explained in progress note or aftercare plan? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

163. Was there a Discharge Assessment completed by a clinician? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

164. Was there a Discharge Assessment by a clinician completed between prior to the 23rd hour of the CSU admission? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

165. Did the Discharge Assessment meet medical necessity criteria if the patient was referred for a higher level of care? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

Restraint & Seclusion (R&S)

166. Was the patient placed in Restraints and/or Seclusion? [yes=100% no=0%]

◯ 0 ◯ 100

167. Was there a dated, timed, signed order for R&S? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

168. If an adult patient was in R&S longer than four (4) hours, was there a new order? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

169. Did the nurse write a progress note documenting evaluating patient within ten (10) minutes of being placed within R&S? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

170. Were a complete set of vital signs taken as soon as possible or within thirty (30) minutes of the start of R&S? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

171. Were a complete set of vitals signs taken every four hours after the initial set of vitals? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

172. Did the Psychiatrist on Duty or Medical Doctor on Duty complete an evaluation of the patient within one (1) hour? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

173. Is the R&S Observation Log for monitoring the patient every 15 minutes complete? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

174. Did the staff document physical condition, extremities, offering fluids, meals (when appropriate), offering toileting, circulation, and Range of Motion, every two (2) hours while in R&S? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

175. After the R&S episode, was the Patient Debriefing Tool completed? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

176. Was the Alternative Interventions to R&S form completed? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

Progress Notes

177. Was Medical Necessity evident in the documentation supporting the billing? [yes=100% no=0%]

◯ 0 ◯ 100

178. Did the Progress notes reflect the staff interventions and the individual's response to the interventions? [yes=100% no=0%]

◯ 0 ◯ 100

179. Are all notes finalized? If no, please list in the comment section. [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

Other Pertinent Documentation

180. Was the Patient Reported Therapeutic Intervention Survey completed upon admission? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

181. Were medications prescribed? [yes=100% no=0%]

◯ 0 ◯ 100

182. Were medications administered? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

183. Was consent for medication obtained? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

184. Are medication orders documented? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

185. Were physicians verbal or telephone orders signed? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

186. If the patient was placed on precautions, were the precaution sheets completed? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

187. Was the Aftercare plan including referral documented? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

188. When a patient has limited English proficiency (LEP), is there evidence that BHS language services were offered? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

189. If the LEP patient refused BHS language services was there a Waiver Form signed? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

190. Is there evidence that a Release of Information (ROI) was signed by the client/caretaker before information was shared? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

191. Is there evidence of a consent form signed for photograph/video taping? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

192. Was client consent to treat obtained or documented reason why not? [yes=100% no=0%]

◯ 0 ◯ 100

193. Is there evidence that an Acknowledgement of Patient's Right's form was signed? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

194. Is there evidence that the Acknowledgement of Receipt form was signed? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

195. Is there evidence that mental health information was given when first receiving specialty mental health service including Medi-Cal Guide and provider list? And/or upon request? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

196. Is there evidence the patient was provided with information on Advanced Directives? [yes=100% no=0%]

◯ 0 ◯ 100

197. Is there evidence the patient was given information about HIPAA? [yes=100% no=0%]

◯ 0 ◯ 100 ◯ 999

Length of Stay

198. Was the patient discharged before 23 hours and 59 minutes? [yes=100% no=0%]

◯ 0 ◯ 100

199. If the patient was discharged after 23 hours and 59 minutes, were services still provided? [yes=100% no=0% N/A=999]

◯ 0 ◯ 100 ◯ 999

200. If the patient was discharged after 23 hours and 59 minutes were services billed? [yes=100% no=0% N/A=999]

If yes, disallow all services.

DHCS reason for recoupment #19a
1) SMHS Service claimed does not match type of SMHS Service documented.

◯ 0 ◯ 100 ◯ 999

SITE COMPLIANCE SKIP LOGIC

Is this a site review case?

- ◯ Yes
- ◯ No

SITE COMPLIANCE QUESTIONS

201. Is the Medi-Cal Site Certification current? [Yes=100% No=0%]

◯ 0 ◯ 100

202. Is the fire clearance current? [Yes=100% No=0%]

◯ 0 ◯ 100

203. Are all staff credentials verified for their scope of practice? [stratify: # yes / # of staff audited = % compliant].

Percent Compliant