ALCOHOL, DRUG & MENTAL HEALTH SERVICES
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Executive Summary: ACBHCS System of Care Audit

Audit Conducted 3rd Quarter of 2016 for the Audit Period of 1/1/16 – 3/31/16

- Random selection of Medi-Cal Children's and Adult Mental Health (MH) services claimed by Master Contract Organizations (MCO, aka CBO) & County Owned and Operated Clinics.
- Thirty-one charts were reviewed from 19 providers (5 County Clinics & 14 MCO's).
- ***Overall claims compliance averaged 41%*** (270 of 651 claimed services) and across providers ranged from 0 to 100%. With Day Rehab claims removed from the sample, claims compliance rose to 52%. As all Day Rehab claims were disallowed—this heavily skewed the average. (The DHCS standard is 95% – 100% for claims compliance.)
- ***Claims compliance for Children's claims was 61% and for Adult claims was 20%.*** With the Day Rehab claims removed, the Adult claims compliance rose to 35%.

- **CLAIMS COMPLIANCE OF 41% IS ONE-HALF OF WHAT IT WAS FROM THE PRIOR SOC AUDITS WHICH AVERAGED 82% (RANGED FROM 81 – 87%). IT IS THEREFORE HIGHLY RECOMMENDED THAT ALL PROVIDERS REVIEW THE COMPLETE AUDIT REPORT AND EVALUATE THEIR PROGRAMS IN THE AREAS OF NON-COMPLIANCE FINDINGS AS A QUALITY IMPROVEMENT ACTIVITY.**

- *Below you will find the key recommendations which should prove instrumental in improving ACBHCS programs' (County & CBO's) Claims and Quality Compliance.*
- The top five (5) significant reasons for claims disallowances were:
  - *Day Rehabilitation Program requirements not met.*
  - *No Signature on Assessment or Medical Necessity not established (including Dx not established by LPHA with required co-signatures).*
  - *No Client Plan in effect at time of service delivery (or non-compliance with Plan requirements, Plan missing signatures, or Service Modality not indicated).*
  - *Progress Note missing, incorrect code, inadequate or no intervention noted, excessive documentation time, incorrect group time calculation, etc.*
  - *Non-billable activity (lock-out, clerical, administrative, voicemail, no show, scheduling, payee, transportation, supervision, vocational, screening tool).*
- ***Quality compliance averaged 80% and ranged from 56–94%*** (in 10 areas & 130 items).
- Additional important Quality non-compliance items were:
  - *Mild-Moderate-Severe Screening Tool and/or CFE/CANS/ANSA were not completed.*
  - ***Safety Plans (or objectives) were not completed for Danger to Self or Others.***
  - *Informed Consents for Medications were not obtained, or were missing elements.*
  - *Required signed Releases of Information were not present & the ACBHCS required "Informing Materials Signature Page" was not present or fully completed.*

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES (ACBHCS)

Mental Health System of Care Audit of ACBHCS Master Contract Organizations and County Owned & Operated Programs

Audit Conducted in Third Quarter of 2016
For Audit Period: 1/1/16 – 3/31/16

Final Report Issued: 3/31/17

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INTRODUCTION:

This chart audit utilized a random sample review of Mental Health (MH) services for the Alameda County Behavioral Health Care Services (ACBHCS) Adult and Children's System of Care. The purpose of this report is to determine the rates of compliance with Specialty Mental Health Services (SMHS) Medi-Cal (M/C) documentation standards for services claimed to Medi-Cal.

This report provides concrete feedback in regard to documentation strengths as well as training needs for the ACBHCS programs audited. Because the selection of claims for the review employed a random sampling method, it may be utilized to generalize findings across the ACBHCS Mental Health System of Care for the audit period as a whole.

The Quality Assurance Office (QA) requested a random sample of all submitted MH claims for the time period of 1/1/2016 – 3/31/2016 from Emanio (database which pulls information from the InSyst Medi-Cal claiming program) for adult and child Medi-Cal beneficiaries. Thirty-one (31) charts of twenty-two (22) unique clients, from nineteen (19) providers, and a total of six hundred and fifty-one (651) claims were reviewed for compliance and quality of care utilizing a standardized chart audit protocol. See Exhibit 1a, 1b & 1c for the lists of claims reviewed by client chart and by provider. Exhibit 2 lists the DHCS Reasons for Recoupment with ACBHCS Claims Comments for fiscal year 2015-2016.

Each chart was reviewed for compliance with Medi-Cal claiming requirements and for ACBHCS 2015-2016 quality of care documentation standards. *(References: ACBHCS Clinical Documentation Standards Manual, 12/3/14 and the ACBHCS CQRT Regulatory Compliance Tools, 4/15/15.)*

CLAIMS REVIEW RESULTS:

Please refer to the Claims Review Spreadsheets (Exhibits 1a, 1b, & 1c), the DHCS Reasons for Recoupment with ACBHCS Claims Comments for fiscal year 2015 – 2016 (Exhibit 2) while reviewing this section.

Overall, of the 651 total claims examined by QA staff, 270 claims (42%) met the documentation standards and 381 claims (58%) were disallowed because they did not meet the standards. **Claims compliance of 42% is approximately one-half of what it was from the prior three SOC audits which averaged 82% (ranged from 81 – 87%). It is therefore highly recommended that all providers review this complete audit report and evaluate their programs in the areas of non-compliance findings as a quality improvement activity.**

In the next section we describe in detail the claims compliance findings by provider age group served, by dollar amount, by chart, by provider, by reason for recoupment of paid claims, and by service modality.

The claims allowance rate for child providers was significantly better than that for adult providers. Of 347 child provider claims, the compliance rate was 61% (39% disallowances). Of 26 TAY provider claims, the compliance rate was 54% (46% disallowances). Of 278 adult provider claims, the compliance rate was 17% (and disallowance rate was 83%).

See Table #1 which specifies claims compliance overall and by provider age group served.

Table #1: Claims Compliance by Age				
Provider Type	**Number of Claims**	**Allowed Claims**	**Disallowed Claims**	**Percent Compliant**
All	651	270	381	42%
Child Provider	347	210	137	61%
TAY Provider	26	14	12	54%
Adult Provider	278	46	232	17%

Note: 100% of Day Rehabilitation claims were disallowed which negatively skewed the compliance rate. If Day Rehab claims are removed from the sample, the overall claims allowance rate rose to 52% (from 42%). As well, the Adult Provider claims compliance then rose to 32% compliance (from 17% compliance).

See Table #2 for changes to claims compliance with Day Rehab services removed.

Table #2: Claims Compliance by Age (With Day Rehab Services Removed).				
Provider Type	**Number of Claims**	**Allowed Claims**	**Disallowed Claims**	**Percent Compliant**
All	519	270	249	52%
Child Provider	347	210	137	61%
TAY Provider	26	14	12	54%
Adult Provider	146	46	100	32%

All claims reviewed (651) totaled $127,343.91. The 270 allowed claims totaled $49,804.59 and the 381 disallowed claims totaled $77,539.32. Please see Table #3 (Claims Compliance by Dollar Amount) below**.**

See Table #3: Claims Compliance by Dollar Amount		
Claims	**Amount**	**Dollars**
Total	651	$127,343.91
Allowed	270	$49,804.59
Disallowed	381	$77,539.32

Due to non-compliance with Mental Health Assessments and/or Client Plans, additional claims, outside of the audit period, were also disallowed. The additional disallowances are noted in the Addendum (by Provider) and totaled $38,652.46.

The breakdown across all providers, for the *number of charts falling into claims compliance ranges* is listed below. This indicates 6.5% of the charts (2 of 31) fell in the compliance range of 95-100%, and 13% (4 of 31) fell in the compliance range of 85% - 100%, with the remaining

87% in the compliance range of below 85%. See Table #4 (Claims Compliance Results by Chart) below:

Table #4: Claims Compliance Results by Chart		
Number of Charts	**Charts % Compliance**	**Percentage of Total**
2	95 – 100%	6.5%
2	85 – 94%	6.5%
1	75 – 84%	3%
0	65 – 74%	0%
26	<65%	84%

The *average claims compliance per provider* indicated 11% (2 of 19) of the providers had charts whose average claims compliance rate fell in the compliance range of 95% – 100%, and 16% (3 of 19) of the providers had charts whose average claims compliance rate fell in the compliance range of 85%- 100%, with the remaining 84% of providers having charts whose average claims compliance rate fell in the compliance range of below 85%. See Table #5 (Claims Compliance Results by Provider) below:

Table #5: Claims Compliance Results by Provider		
Number of Providers	**Average Chart Compliance**	**Percentage of Total**
2	95 – 100%	11%
1	85 – 94%	5%
1	75 – 84%	5%
0	65 – 74%	0%
15	<65%	79%

The thirty-three (33) ACBHCS reasons for claims disallowances in this audit are listed below in descending frequency. Please refer to Exhibit #2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for FY 2015-2016 for categories of claims disallowances. See Table #6 (Reasons for Recoupment of PAID Claims by Frequency) below:

Table #6: Reasons for Recoupment of PAID Claims by Frequency				
DHCS Reasons for Recoupment	**Reason for Recoupment**	**Type of Service**	**Frequency**	**% of Reasons for Disallowance**
19a (10)	No service was provided: Day Rehabilitation did not include all the required service components.	Day Rehabilitation	110	11%
19a (11)	No service was provided: The total number of minutes/hours the client actually attended Day Rehabilitation were not documented.	Day Rehabilitation	110	11%
7a	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.	Client Plan	101	10%
19a13	No service was provided: Day Rehabilitation did not include all program requirements (program/group descriptions, weekly calendar, etc.).	Day Rehabilitation	73	7%

1b	Documentation in the medical record does not establish a primary diagnosis from the DHCS Medi-Cal Included Diagnosis list for the full audit period: NO ASSESSMENT WITH INCLUDED DIAGNOSIS PRESENT FOR DATE OF SERVICE.	Assessment	69	7%
2b	Documentation in the medical record does not establish that, as a result of the primary diagnosis, there is at least one of the following: – A significant impairment in an important area of life functioning; – A probability of significant deterioration in an important area of life functioning; – A probability the child will not progress developmentally as individually appropriate; or – For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate. NO ASSESSMENT PRESENT FOR DATE OF SERVICE.	Assessment	69	7%
3b	Documentation in the medical record does not establish that the focus of the proposed intervention is to address the condition of the primary diagnosis as it relates to: – A significant impairment in an important area of life functioning; – A probability of significant deterioration in an important area of life functioning; – A probability the child will not progress developmentally as individually appropriate; and – For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate NO ASSESSMENT PRESENT FOR DATE OF SERVICE	Assessment	69	7%
4b	Documentation in the medical record does not establish 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 individually appropriate; or – For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition. NO ASSESSMENT PRESENT FOR DATE OF SERVICE	Assessment	69	7%
5a Initial 6a Annual	SMHS Service does not relate back to a current mental health objective in Client Plan.	Treatment Plan Progress Note	63	6%
19a (1)	No service was provided: SMHS service claimed does not match type of SMHS service documented.	Progress Note	55	6%
5b Initial 6b Annual	Service Modality Claimed is not indicated in the Client Plan	Treatment Plan Progress Note	53	5%
19a (12)	No service was provided: the client did not receive the minimum required hours in order to claim for full or half day rehabilitation services.	Day Rehabilitation	41	4%
10c	The time claimed was greater than the time documented:	Progress Note	17	2%

	TIME NOTED FOR DOCUMENTATION IS EXCESSIVE**.**			
5c Initial 6c Annual	No Client Plan or Plan Update for date of service.	Client Plan	17	2%
10a	The time claimed was greater than the time documented : DOCUMENTATION *CONTENT* DOES NOT SUPPORT AMOUNT OF TIME CLAIMED.	Progress Note	16	2%
19a (6)	No service was provided: Non SMHS Service Intervention.	Progress Note	13	1%
5d Initial 6d Annual	Client Plan is missing required staff signature(s) for date of service.	Client Plan	13	1%
13b	The progress note indicates that the service provided was solely for vocational service that has work or work training as its actual purpose.	Progress Note	4	<1%
17b	The progress note indicates the service provided was solely clerical: Non- billable activity – administrative.	Progress Note	4	<1%
17e	The progress note indicates the service provided was solely clerical: Non- billable activity – making appointment w/client related.	Progress Note	4	<1%
19a (8)	Duplication of Services (Same service billed twice by same provider OR by different providers without documentation to support co-providers).	Progress Note	4	<1%
11	The service was provided while the client was in a lock-out setting (i.e. IMD, Jail, etc.)	Progress Note	3	<1%
1c	Documentation in the medical record does not establish a primary diagnosis from the DHCS Medi-Cal Included Diagnosis list for the full audit period (DIAGNOSIS IS NOT ESTABLISHED BY LICENSED LPHA OR NOT CO-SIGNED BY LICENSED LPHA IF ESTABLISHED BY A WAIVERED STAFF OR REGISTERED INTERN.)	Assessment	2	<1%
2c	Documentation in the medical record does not establish that, as a result of the primary diagnosis, there is at least one of the following: – A significant impairment in an important area of life functioning; – A probability of significant deterioration in an important area of life functioning; – A probability the child will not progress developmentally as individually appropriate; or – For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate: (DIAGNOSIS IS NOT ESTABLISHED BY LICENSED LPHA OR NOT CO-SIGNED BY LICENSED LPHA IF ESTABLISHED BY A WAIVERED STAFF OR REGISTERED INTERN.)	Assessment	2	<1%
3c	Documentation in the medical record does not establish that the focus of the proposed intervention is to address the condition ot the primary diagnosis as it relates to: – A significant impairment in an important area of life functioning; – A probability of significant deterioration in an important area of life functioning; – A probability the child will not progress developmentally as individually appropriate; and – For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate: (DIAGNOSIS IS NOT ESTABLISHED BY LICENSED LPHA OR NOT CO-SIGNED BY LICENSED LPHA IF ESTABLISHED BY A	Assessment	2	<1%

	WAIVERED STAFF OR REGISTERED INTERN.)			
4c	Documentation in the medical record does not establish 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 individually appropriate; or – For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition: ASSESSMENT NOT SIGNED BY LPHA. (DIAGNOSIS IS NOT ESTABLISHED BY LICENSED LPHA OR NOT CO-SIGNED BY LICENSED LPHA IF ESTABLISHED BY A WAIVERED STAFF OR REGISTERED INTERN.)	Assessment	2	<1%
9a	No progress note was found for service claimed: PN missing.	Progress Note	2	<1%
12	The service was provided while the client was in juvenile hall.	Progress Note	1	<1%
14b	Inaccurate calculation for a group service.	Progress Note	1	<1%
15a	The progress note was not signed: Missing provider signature	Progress Note	1	<1%
16a	The service provided was solely transportation: Non-billable activity – transportation related	Progress Note	1	<1%
17c	The service provided was solely clerical: Non-billable activity – voicemail activity.	Progress Note	1	<1%
19a (2)	No service was provided: PN does not include Clinician's Intervention/or Client Response component.	Progress Note	1	<1%
Totals			993	100%

The reasons for claims disallowances may be grouped into categories.

Thirty-three percent (33%) of the reasons for disallowance were for Day Rehabilitation Services because: the charts did not include all the program service requirements; the charts did not include the total number of minutes/hours the client attended the program; the charts did not include all the program requirements (program/group descriptions, weekly calendar, etc.); or because the client did not receive the minimum required hours in order to claim for the service for Day Rehabilitation services.

Approximately thirty percent (30%) of the reasons for disallowance were related to the Assessment because: medical necessity was not met; there was no diagnosis or Assessment for the date of service; or the Assessment was not signed by a licensed LPHA.

Twenty-four percent (24%) of the reasons for disallowance were related to the Client Plan because: there was no documentation of the client's or legal guardian's participation in the Client Plan, or a written explanation of the client's refusal or unavailability to sign the Client Plan; the service did not related back to a current Mental Health Objective on the Client Plan; the service

Modality was not listed on the Client Plan; there was no Client Plan or Client Plan update for the date of service, or the Client Plan was missing the required staff signature.

Approximately thirteen percent (13%) of the reasons for disallowance were related to the Progress Notes because: the service claimed did not match the type of service documented; the time noted for documentation was excessive, the documentation content did not support the amount of time claimed; the intervention was a non-specialty mental health intervention, the service provided was solely vocational, the service was a non-billable activity: making an appointment with the client, voicemail activity, or administrative activity; the service was a duplication of service: the same service billed twice by the same provider or by different providers without documentation to support co-providers; the service was provided while the client was in a lock-out setting; the Progress Note was missing; inaccurate calculation for a group service; the Progress Note was not signed; the service was solely transportation related; the Progress Note does not include the clinician's intervention component.

Table #7 below categorizes the reasons for claims disallowances as described above:

Table #7 Reasons for Claims Disallowances	
Reasons Category	Percent of Disallowance Reasons
Day Rehabilitation	33%
MH Assessment	30%
Client Plan	24%
Progress Notes	13%

The claims disallowed are listed below by the percentage disallowed within each service modality type (in descending frequency). Please note that the MH service modality most frequently disallowed was Day Rehabilitation. See Table #8 (Percentage of Modality Types Disallowed) below:

Table #8: Percentage of Claims Disallowed by Modality Type			
Disallowed MH Services by Modality	**Number of Claims Disallowed**	**Total Number of Claims (by type) across all charts audited.**	**Percentage of Claims Disallowed by Modality Types**
Day Rehabilitation Full	132	132	100%
Katie A	2	2	100%
Behavioral Evaluation	5	6	83%
Crisis Therapy	8	11	73%
Case Management /Brokerage	69	96+	72%
Medication Training/Support	7	10	70%
Individual Rehabilitation	47	77	61%
Psychotherapy	43	78	55%

Family Therapy	7	17	41%
Plan Development	8	20	40%
Psychiatric Diagnostic Evaluation	10	26	38%
Collateral	37	115	32%
E/M	4	21	19%
Group Rehabilitation	2	40	<1%
Total	381	651	59%

QUALITY REVIEW:

The Quality Review determined if the standards for documentation of Medi-Cal Specialty Mental Health Services had been met. Ten (10) Quality Review areas, with 130 items, were analyzed in this audit. They included: *Informing Materials, (Mild-Moderate-Severe) Screening, Medical Necessity, Assessments, Client Plans, Special Needs, Medication Log Issues, Progress Notes, and Chart Maintenance, and a separate section which applies to Day Rehabilitation only*.

The Quality Review also verified that medical necessity for each claimed service and its relevance to both the current Mental Health Assessment and Client Plan had been met. The following section explains the results from the quality review process. Please refer to the Quality Review Spreadsheet (Exhibit 3), **and** the Quality Review Key (Exhibit 4) while reviewing this section.

Please note that the Quality Review Items (QRIs) are inclusive of reasons for claims disallowances. Not all QRIs are reasons for disallowance—see Quality Review Item (QRI) descriptions in this report for those that are also a reason for claims disallowance and recoupment.

As you read the report you will find percentages for each QRI which represents the ratio of *adherence* with required chart documentation. Following each of the QRIs there is a reference for the corresponding QRI Number (QRI #) listed in (Exhibits 3 & 4).

QRIs were evaluated from either a categorical or stratified approach. Most of the QRIs required a categorical method resulting in either a 'Yes/No' or 'True/False' review. In these items, the scores are either 100% for Yes/True or 0% for No/False. Wherever possible, scoring for a QRI was stratified allowing for a more accurate portrayal of documentation compliance.

The stratified approach is described in the example below:

- *QRI # 65 "There is a Progress Note for every service contact"*:
  - *If there were 10 Progress Notes that were claimed during the audit period and 8 were present in the chart, the score for that chart on this item would be 80%. Each chart would be evaluated similarly. Then, the percentages for all charts are averaged to obtain an overall compliance score for that quality review item.*

Some requirements do not apply to specific charts, such as when clients do not receive medication support services or when the client was discharged prior to the due dates for the Assessment or Client Plan. These are noted as 'N/A' in the Quality Review Spreadsheet, and are not incorporated into the final score for that QRI.

It is important to note that some Quality Review items are more crucial than others (i.e. presence of Medi-Cal Included Diagnosis versus appropriate filing of documents within chart sections); therefore examining the score for each individual QRI is more informative and indicative of documentation quality than the overall Quality Review score.

Quality Review Results:

The overall compliance rate for the Quality Review was 80% (see Exhibit 3). The results of the Quality Review for 31 charts by compliance ranges demonstrated that 45% of the charts scored 85% or higher in Quality compliance, 45% fell in the compliance range of 65 – 85%, and 10% fell below 65%. See Table #9: Quality Review Compliance by Chart).

Table #9: Quality Review Compliance by Chart		
Number of Charts	**Quality Compliance Rate**	**Percentage**
0	95 – 100%	0%
14	85 – 94%	45%
8	75 – 84%	26%
6	65 – 74%	19%
3	<65%	10%

Quality Review Items:

- ACBHCS Informing Materials:
  - 70% (21/30) of the charts had the most recent required ACBHCS Informing Material signature page completed and signed on time (within 30 days of EOD or annually by EOD) OR if late, documents reason in Progress Notes. (QRI #11)

- ACBHCS Screening:
  - 30% (6/20) of the charts had the most recent required ACBHCS Screening Tool completed, prior to the opening of the client episode, prior to the reauthorization of services, and/or at the time of any Client Plan updates, when required per program. (QRI # 12)
  - 30% (6/20) of the charts showed evidence that the mental health condition meets the criteria for moderate to severe based on the most recent required ACBHCS Screening Tool, when required per program. (QRI #13)
- Medical and Service Necessity (*These are crucial items that if not met result in claims disallowances)*:
  - 65% (20/31) of the charts had documentation that established a primary diagnosis from the DHCS Medi-Cal Included Diagnosis list **for the full audit period.** (QRI #14)

- 65% (20/31) of the charts had documentation **for the full audit period** that established 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; or
  --If EPSDT: MH condition can be corrected or ameliorated. (QRI #15)
- 65% (20/31) of the charts had documentation **for the full audit period** that established 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; or
  --If EPSDT: MH condition can be corrected or ameliorated. (QRI #16)
- 65% (20/31) of the charts had documentation **for the full audit period** that established 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; or
  --If EPSDT: Correct or ameliorate the condition. (QRI #17)

➢ <u>Assessments:</u>

- 86% (25/29) of the charts had presenting problems and relevant conditions included in the most recent required assessment. (QRI #18)
- The compliance rate for assessing the four (4) required areas of psychosocial history in the most recent required assessments across all charts was 86%. (QRI #19)
  - *The psychosocial history should include: 1) living situation, 2) daily activities, 3) social support, and 4) history of trauma or exposure to trauma.*
- The compliance rate for assessing the four (4) required areas of current and past psychiatric medications (or lack thereof) the client has received in the most recent required assessments across all charts was 45%. (QRI#20)
  - *This item should include: 1) current psychiatric medications, 2) duration of treatment with current psychiatric medications, 3) past psychiatric medications, 4) duration of treatment with past psychiatric medications.*
- The compliance rate for assessing the four (4) required areas of current and past medications to treat medical conditions (or lack thereof) the client has received in the most recent required assessments across all charts was 47%. (QRI #21)
  - *This item should include: 1) current medications to treat medical conditions, 2) duration of treatment with current medications to treat medical conditions, 3) past medications to treat medical conditions, 4) duration of treatment with past medications to treat medical conditions.*

- 66% (19/29) of the charts had a mental status exam (MSE) included in the most recent required assessment. (All noted abnormal findings or impairments must be described to receive credit for this item). (QI #22)
- 76% (22/29) of the charts included the assessment of risks to client in the most recent required assessment. (For credit, Danger to Self must be assessed and if indicated, a description is required). (QRI #23)
- 76% (22/29) of the charts included the assessment of risks to others in the most recent required assessment. (For credit, Danger to Others must be assessed and if indicated, a description is required). (QRI #24)
- 73% (11/15) of the charts included pre/perinatal events and relevant/significant developmental history for youth in the most recent required assessment. (QRI #25)
- 93% (27/29) of the charts had documentation of the client/family strengths in achieving client plan goals or objectives included in the most recent required assessment. (QRI #26)
- 72% (21/29) of the charts documented allergies/adverse reactions/sensitivities, or lack thereof, in the record. (QRI #27)
- 60% (18/30) of the charts displayed allergies/adverse reactions/sensitivities, or lack thereof, on the chart cover, or if an EHR it is in the field/location designated by the clinic. (QRI #28)
- The compliance rate for assessing the three (3) required areas of relevant medical conditions/history (or lack thereof) in the most recent required assessments across all charts was 56%. (QRI #29)
    - *This item should include: 1) medical conditions, 2) name of current provider, 3) address of current provider.*
- The compliance rate for assessing the four (4) required areas of mental health history (or lack thereof) in the most recent required assessments across all charts was 52%.
  (QRI #30)
    - *This item should include: 1) previous treatment (including inpatient admissions), 2) previous providers, 3) therapeutic modalities, 4) client response to treatment.*
- The compliance rate for assessing the required seven (7) areas of substance exposure/substance use in the most recent required assessments across all charts was 44%. (QRI #31)
    - *All clients must be assessed for past and present substance exposure/substance use of tobacco, alcohol, caffeine, complementary & alternative medications, over-the-counter medications, prescription medications, and illicit drugs.*
- 80% (20/25) of the charts had the most recent required Annual Community Functioning Evaluation or CANS/ANSA completed for the audit period. (QRI #32)
- 62% of all assessments (initial and/or annual) required during the audit period across all charts were completed and signed by all required participants on time. (QRI #33)

- *This is a crucial item that if not met, results in claims disallowances (until met).*

➢ Client Plans:

- 67% of the mental health objectives listed in all required Client Plans for the audit period, across all charts, were current and addressed the symptoms/impairments of the included diagnosis. (QRI #34)
  - *There must be at least one current mental health objective on the Client Plan that addresses the symptoms/impairments of the included diagnosis in order to claim for services. This is a crucial item that if not met, results in claims disallowances (until met).*
- 61% of the mental health objectives listed in the most recent required Client Plan, across all charts, was observable or measureable with timeframes and preferably baselines. (QRI #35)
- 87% of the proposed service modalities for planned services that were claimed were listed in all required Client Plans for the audit period, across all charts. (QRI #36)
  - *This is a crucial item that results in disallowances for all claimed service modalities which are NOT listed in the Client Plan.*
  - *Assessment, Plan Development, Interactive Complexity, and Crisis services do not need to be listed separately in the Client Plan.*
- 35% of the proposed service modalities listed in the most recent required Client Plans for the audit period, across all charts, included frequency and time frames. (QRI #37)
  - *All modalities should list the frequency and timeframes (i.e. Psychotherapy 1x/week, AND as needed, for 12 months).*
- 67% of the proposed service modalities listed in the most recent required Client Plans for the audit period, across all charts, included detailed descriptions of provider interventions. (QRI #38)
  - *Please note DHCS requirement: Client Plans must include detailed descriptions of proposed interventions that address stated impairments and mental health objectives. For example: "In psychotherapy sessions, clinician will utilize CBT techniques such as x, y, & z in order to build client's awareness and insight around triggers to her anxiety…" "In individual rehabilitation sessions, clinician will teach client relaxation skills to manage her anxiety…"*
- 40% (6/15) of the charts had a plan for containment for risk(s) (within the last 90 days of indication of risk or potential risk) to client (DTS) if applicable. (QRI #39)
- 29% (5/17) of the charts had a plan for containment for risk(s) (within the last 90 days of indication of risk or potential risk) to others (DTO) if applicable. (QRI #40)
  - *When there is a risk to self or others present within the last 90 days of the service date, there should be a Treatment Plan goal with objectives that address the identified risks, and/or a specific Safety Plan. Progress Notes*

must also document the ongoing assessment and interventions of these risks.

- 91% (20/22) of the charts showed evidence of coordination of care when it was applicable. (QRI #41)
- 73% (8/11) of all Client Plans required for the audit period, across all charts, were updated when there were significant changes in service, diagnosis, or focus of treatment. (QRI #42)
    - *This is a crucial item that results in disallowances for all claimed services after the Client Plan should have been updated.*
- 89% (8/9) of the most recent required Client Plans for the audit period, across all charts, were signed/dated by MD/NP if applicable. (QRI #43)
- 52% of all Client Plans required for the audit period, across all charts, were signed and dated by the client or legal representative when appropriate or there was documentation of client refusal or unavailability. (QRI #44)
    - *This is a crucial item that if not met, results in claims disallowances (until met).*
    - *If the client signature was late or not present, the reason must be indicated on the signature line and documented in a Progress Note.*
- 65% (15/23) of the most recent required Client Plans (or related progress notes) for the audit period included documentation of the client's participation in and agreement with the Client Plan. (QRI #45)
    - *Credit was given for this item if the Client Plan contained a client (or guardian) signature; however, the Client Plan (or related progress note) should include a statement of the client's participation and agreement with the Client Plan.*
- 48% (11/23) of the most recent required Client Plans for the audit period indicate that the client or representative (signatory) was offered a copy of the plan. (QRI #46)
    - *If the client speaks a threshold language, 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. (Threshold languages: Spanish, Cantonese, Mandarin, Farsi, Vietnamese, Korean, Tagalog). If the Plan in the record is not in English, an English translation of the Plan must also be placed in the chart.*
- 80% of all Client Plans required for the audit period, across all charts, were completed and signed on time by all required staff. (QRI #47)
    - *This is a crucial item that if not met, results in claims disallowances (until met).*
- 76% (19/25) of the most recent required Client Plans for the audit period, across all charts, contained a Tentative Discharge Plan as part of the Client Plan. (QRI #48)

- *This item should include a time frame and clinical indicators for when the client is expected to be ready to be discharged. Time frames should be consistent throughout the Client Plan.*

➢ Special Needs:

- 86% (25/29) of the most recent required Client Plans or Assessments for the audit period noted the client's cultural and communication needs, or lack thereof. (QRI #49)
- Of those with noted cultural and communication needs, 53% (8/15) of those charts addressed them as appropriate. (QRI #50)
- 83% (24/29) of the most recent required Client Plans or Assessments for the audit period noted client's physical limitations, or lack thereof. (QRI #51)
- Of those with noted physical limitations, 62% (8/13) of those charts addressed the physical limitations as appropriate. (QRI #52)

➢ Medication Log Issues:

- 100% (9/9) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which was updated at each visit with date of prescription, when applicable. (QRI #53)
- 100% (9/9) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which was updated at each visit with the drug name, when applicable. (QRI #54)
- 100% (9/9) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which was updated at each visit with the drug strength/size, when applicable. (QRI #55)
- 100% (9/9) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which was updated at each visit with the instruction/frequency for administration of the medication, when applicable. (QRI #56)
- 100% (9/9) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which is updated at each visit with the prescriber's signature or initials, when applicable. (QRI #57)
- 84% of the required Informed Consent for Medication(s) and JUV 220/3 (required for foster children) were completed and signed when applicable. (QRI #58)
  - *This is a significant item that must be addressed for all charts in which psychotropic medications are prescribed.*
- The compliance rate for including the twelve (12) required components of all required Informed Consents for Medication(s) for the audit period, across all charts was 43% (QRI #59)
  - *All Consents for Medication must include: 1) Rx name, 2) specific dose or range, 3) administration route, 4) expected uses/effects (reasons used), 5) short term and long term (beyond 3 months) 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 the client was offered a copy of consent (for #12 only, if the client*

speaks a threshold language, the consent or related progress note should contain 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).

- 50% of the E/M Progress Notes audited for E/M standards were compliant. (QRI #60)
  - *Note, this is for informational purposes only. The medication services were audited to the DHCS Medi-Cal standard only.*

➢ Progress Notes (*Each of the percentages reflect the results across all charts.*)

- There was a Progress Note for 99% of all service contacts. (For Day Rehabilitation services a Weekly progress note is required). (QRI #61)
- 79% of the Progress Notes had the correct CPT Code/exact procedure name, and/or INSYST service code for the mental health services provided. (QRI #62)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the Progress Notes indicated the correct date of service. (For Day Rehabilitation services a Weekly progress note with the corresponding dates of service is required). (QRI #63)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 96% of the Progress Notes indicated the correct location of service. (QRI #64)
- 100% of the Progress Notes **for time based codes** documented both face-to-face time and total time. (QRI #65)
  - *For service codes that are time based--this is a crucial item that if not met, results in claims disallowances.*
- 100% of the Progress Notes documented time that equaled the time that was claimed. (QRI #66)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 94% of the Progress Notes had reasonable time noted for documentation. (QRI #67)
  - *This is a crucial item that if not met, may result in claims disallowances.*
- 95% of the Progress Notes had documented content that supported the amount of direct service time claimed. (QRI #68)
  - *This is a crucial item that if not met, may result in claims disallowances.*
- 96% of the Progress Notes included a description of that day's **P**resenting **P**roblem/evaluation/**B**ehavioral presentation or **P**urpose of the service. (QRI #69)
- 96% of the Progress Notes included a description of a staff specialty mental health service (SMHS) **I**ntervention for that day's service. *(QRI #70)
  - *This is a crucial item that if not met, results in claims disallowances.*
  - *Interventions must be related to client's diagnosis, symptoms, impairments, and mental health objectives listed in Client Plan.*
- 99% of the Progress Notes included a description of that day's client **R**esponse (or a **R**esponse from other persons involved in the client care) to the intervention.* (QRI #71)

- 81% of the Progress Notes included a description of the client's and/or staff's **P**lan/follow up, including referrals to community resources and other agencies and any follow up care when appropriate. *(QRI #72)
    - **The "P/BIRP" Progress Note Format is not required, but the associated elements are.*
- 99% of the group service Progress Notes included correct calculation of the time and listed the number of clients served. (QRI #73)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 80% of the Progress Notes documented services that related back to the mental health objectives listed in the Client Plan. (QRI #74)
    - *This is a crucial item that if not met, may result in claims disallowances.*
- 89% of the Progress Notes addressed unresolved issues from prior services, when applicable. (QRI #75)
- 100% of the Progress Notes were signed. (QRI #76)
- 87% of the Progress Notes signatures included the date. (QRI #77)
- 91% of the Progress Notes signatures included the staff Medi-Cal designation (may also list credential on Provider Signature Page/Sheet in chart). (QRI #78)
    - *The signature is a crucial item that if not met, results in claims disallowances.*
    - *Progress Notes must be signed and dated and list an acceptable Medi-Cal credential (license/registration/waiver/MHRS/Adjunct).*
- 100% of the Progress Notes had a completion line after the signature if applicable (N/A if EHR). (QRI #79)
- 99% of the claimed services were NOT provided while the client was in a lock-out setting such as a psychiatric hospital or IMD (unless with a d/c plan within 30 days for placement purposes only), or jail. (QRI #80)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the claimed services were NOT provided while the client was in juvenile hall (unless documentation of an adjudication order is obtained) (QRI #81)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 97% of the claimed services provided were NOT for academic/educational service, vocational service, recreation and/or socialization (socialization is defined as consisting of generalized activities that did not provide systematic individualized feedback to the specific targeted behaviors). (QRI #82)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 99% of the claimed services provided were NOT transportation related. (QRI #83)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 97% of the claimed services provided were NOT clerical related. (QRI #84)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the claimed services provided were NOT payee related. (QRI #85)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the claimed services were provided when the case was open to the provider. (QRI #86)
- 100% of the claimed services were provided when the client was NOT deceased. (QRI #87)

- 99% of the claimed services provided were NOT a non-billable activity for completion of the ACBHCS Screening Tool. (QRI #88)
- 99% of the claimed services provided were NOT a duplication of service. (QRI #89)
  - *Duplication of services is the same service billed twice (or more) by the same staff within the same agency OR by different staff either within the same agency or in different agencies without documentation to support the clinical need for co-staff.*
- 100% of the claimed services provided were NOT supervision related. (QRI #90)
- 89% of the progress notes that documented a discharge note/summary, only claimed as part of a billable service with the client present or contained activity for referral purposes. (QRI #91)
- 73% of the progress notes were completed and signed within the "late note" timeline required by the MHP) (QRI #92)
  - *The current ACBHCS PN "late note" timeline of 5 working days was utilized.*
  - *For Day Rehabilitation Services a weekly progress note is required to be completed by the week following services.*
- 42% of the progress notes that were late indicated "late note" in the body of the progress note. (QRI #93)
- 97% of the progress notes documented the language that the service was provided in (or noted it in the treatment plan that the consumer was English-speaking and all services were to be provided in English). (QRI #94)
- 98% of the progress notes indicated that interpreter services were used and the relationship to client was indicated, if applicable. (QRI #95)
- 100% of the progress notes documented that the service was provided within the scope of practice of the person delivering the service. (QRI #96)

➢ <u>Chart Maintenance:</u>

- 94% (29/31) of the charts noted the admission date correctly (EOD noted in chart should match InSyst). (QRI #97)
- 71% (22/31) of the charts had emergency contact information in the designated InSyst field (best practice is to also have this information in a specific location in the chart or EHR). (QRI #98)
- 83% of the required signed releases of information were present. (QRI #99)
- The compliance rate for legibility in the charts was 99%. (QRI #100)
  - *This is a crucial item that if not met, may result in claims disallowances.*
  - *Five (5) areas of documents were reviewed for this quality item:*
    - *Assessments, Client Plans, Non-Clinical Forms, Progress Notes, and MD/NP Documents.*
- 98% of the signatures on the documents throughout all charts were legible (or printed name under signature or signature sheet was present). (QRI #101)
  - *This is a crucial item that if not met, may result in claims disallowances.*
- When applicable, 100% of the charts contained service-related client correspondence in the client's preferred language. (QRI#102)

- N/A. When indicated, the charts had treatment specific information provided to the client in an alternative format (e.g., braille, audio, large print, etc. (QRI#103)
- 96% (27/28) of the charts maintained a clinical record where documents were filed appropriately. (QRI #104)
- 87% of the pages across all charts identified the client (by name or InSyst #). (QRI #105)
- 100% (11/11) of the charts indicated the discharge/termination date correctly (matching InSyst), when applicable. (QRI #106)
- 92% of the documentation in the charts did not contain significant cut and paste activity. (QRI #107)
    - *This is a crucial item that if not met, may result in claims disallowances.*
    - *Five (5) areas of documents were reviewed for this quality item:*
        - *Assessments, Client Plans, Non-Clinical Forms, Progress Notes, and MD/NP Documents.*
- 90% of the charts contained documentation which only used county-designated acronyms and abbreviations. (QRI #108)

➢ Day Rehabilitation Only *(These are crucial items that if not met result in claims disallowances):*

- 100% (4/4) of the charts contained written weekly schedules for the audit period which showed that a community meeting occurred at least once a day. (QRI #109)
- 75% (3/4) of the charts contained written weekly schedules for the audit period which showed that the community meeting included a staff person who is a physician, a licensed/waivered/registered psychologist, a clinical social worker or a marriage and family therapist; or a registered nurse, psychiatric technician, licensed vocational nurse; or mental health rehabilitation specialist. (QRI #110)
- 100% (4/4) of the charts contained written weekly schedules for the audit period which showed that the therapeutic milieu included Process Groups. (QRI #111)
- 100% (4/4) of the charts contained written weekly schedules for the audit period which showed that the therapeutic milieu included Skill Building Groups. (QRI #112)
- 100% (4/4) of the charts contained written weekly schedules for the audit period which showed that the therapeutic milieu included Adjunctive Therapies. (QRI #113)
- 25% (1/4) of the charts contained documentation in the progress notes or Client Attendance Log that showed the total number of minutes/hours the client attended the program. (QRI #114)
- 33% (1/3) of the charts contained documentation in the progress notes or Client Attendance Log that showed the total time of minutes/hours the client actually attended the program that day if the client was unavoidably absent. (QRI #115)
- 33% (1/3) of the charts contained documentation in the progress notes or Client Attendance Log that showed the client was present for at least 50 percent of the scheduled hours of operation for that day if the client was unavoidably absent. (QRI #116)

- 33% (1/3) of the charts contained a separate entry in the record (progress notes) documenting the reason the client was unavoidably absent if applicable. (QRI #117)
- 100% (1/1) of the charts contained documentation in the progress notes that showed that the provider re-evaluated the client's need for Day Rehabilitation if absences are frequent, and has taken appropriate action. (QRI #118)
- 50% (2/4) of the charts contained documentation in the progress notes that showed 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. Note: This contact may be face-to-face or by email, phone, etc. Adult clients may decline this component if it is documented in the record. (QRI #119)
- 25% (1/4) of the charts contained documentation in the Written Weekly Schedule, Daily Sign-in Sheets, and progress notes that showed 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. (QRI #120)
- 75% (3/4) of the charts contained documentation in the Written Weekly Schedule that showed there was at least one staff person present and available to the group in the therapeutic milieu. (QRI #121)
- 25% (1/4) of the charts contained documentation in the Written Weekly Schedule or the Daily Sign-in sheets that showed there was 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. (QRI #122)
- 100% (4/4) of the charts contained a Written Program Description which describes the specific activities of each service and reflects each of the required components of the services. (QRI #123)
- 75% (3/4) of the charts contained a Written Weekly Schedule which identifies when and where the service components will be provided and by whom. (QRI #124)
- 25% (1/4) of the charts contained a Written Weekly Schedule which lists the program staff, their qualifications, and the scope of their services. (QRI #125)
- N/A. The charts contained documentation that showed, if the provider used staff who are also staff with other responsibilities (e.g., staff of a group home, a school, or another mental health treatment program), the scope of responsibilities for these staff and the specific times in which Day Rehabilitation activities are being performed exclusive of other activities. (QRI #126)
- 100% (4/4) of the charts contained a Mental Health Crisis Protocol. (QRI #127)
- N/A. The charts contained documentation that services were authorized in advance if provided more than five days per week. (QRI #128)
- 100% (2/2) of the charts contained documentation that showed that services were authorized at least every 6 months for continuation of Day Rehabilitation services. (QRI #129)

- N/A. The charts contained documentation that showed that the provider requested authorization for mental health services provided concurrently with Day Rehabilitation, excluding services to treat emergency and urgent conditions. (QRI #130)

RESOLUTION OF FINDINGS

All Nineteen (19) providers that were audited have a unique section in the Addendum individualized to the findings of their reviewed chart(s). Each section summarizes the audit findings for the Nineteen (19) providers, and gives instructions for submitting the required Claims Recoupment with a Plan of Correction (POC) or Quality Improvement Plan (QIP). Each provider will also receive a Provider Audit Findings Letter detailing the findings for their chart(s), needed follow-up, and an individualized Plan of Correction which lists all items to be addressed.

If you have any questions regarding the findings of this audit, you may contact:

Jeffery Sammis PsyD
jsammis@acbhcs.org
(510) 567-8208

(***Please do not submit Client Protected Health Information via unencrypted email***)
If you feel that PHI information needs to be sent you must use the Alameda County Secure Email Message Center. If you have not used this encrypted e-mail service before, you may need to register your e-mail account. Here is the link to log on: https://game-message-portal.com/s/login?b=acgov

Claims Recoupment
The total amounts to be recouped are listed in the Addendum for those eighteen (18) providers who had claims disallowances. Directions for submitting disallowances for recoupment are given in the Provider Audit Findings Letters.

Informal Appeal to ACBHCS of Claims Disallowances
If the provider wishes to appeal any of the claims disallowance, they may do so by submitting an informal appeal letter in writing, along with supporting documentation, postmarked within thirty (30) calendar days of the issue date of this report. Any appeals postmarked beyond 30 days will not be reviewed and will be denied. The appeal letter should be addressed to Donna Fone, LMFT, LPCC, Quality Assurance Administrator, Alameda County Behavioral Health Care Services, 2000 Embarcadero, Suite 400, Oakland, CA 94606. ACBHCS shall respond to the informal appeal within 60 days of the receipt of the appeal.

DHCS Appeal
(Note: DHCS only accepts appeals of disallowed claims.)

Per CA Code of Regulations, Title 9, 1850.350: in lieu of, or after, the informal appeal to ACBHCS the provider may choose to appeal to the Department of Health Care Services in writing, along with supporting documentation, within 60 calendar days from the date of

ACBHCS's written Audit Findings (or ACBHCS informal appeal findings) to the provider. Supporting documentation shall include, but is not limited to: (1) Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos; (2) Clinical records supporting the existence of medical necessity if at issue; (3) A summary of reasons why the MHP should have approved the MHP payment authorization; and (4) A contact person(s) name, address and phone number.

Refer to CA Code of Regulations, Title 9, 1850.350 for more details on the DHCS appeal process.

Submit your appeal via email to MHSD-Appeals@dchs.ca.gov (Client Protected Health Information must be sent via secure e-mail) or via mail to:

John Lesley
Mental Health Services Division
Department of Health Care Services
POB 997413, MS 2702
Sacramento, CA 95899-7413

Plan of Correction (POC)
Listed in the Addendum are the eighteen (18) providers with claims disallowances who are required to submit a Plan of Correction. The POC should address the resolution of each of the Quality Review items and disallowed claims reasons indicated on the individual provider's Plan of Correction Template. Please include time frames for the completion of the POC objectives.

*The implementation of the POC should be applied to **all** of the agency programs that are contracted to provide Specialty Mental Health Services Medi-Cal. Please use Exhibit 5 POC/QIP Template.*

Providers must submit the detailed POC to the Quality Assurance Office no later than thirty (30) calendar days from the date of this reports issuance. They must submit your plan of correction by email to:

Jeffery Sammis Psy.D
jsammis@acbhcs.org

If the provider feels that PHI information needs to be sent they must use the Alameda County Secure Email Message Center. If they have not used this encrypted e-mail service before, they may need to register their e-mail account. Here is the link to log on: https://game-message-portal.com/s/login?b=acgov

Note: Please do not submit a POC if an Informal Appeal for disallowed claims has been filed with ACBHCS. Please do not submit a POC if a Formal Appeal has been made to DHCS. The provider must inform the QA department if they plan to make an appeal to the DHCS. The Due date of the POC will be extended accordingly. Any requested POC will be due subsequent

to the outcome of the Formal or Informal Appeal. Also, Quality Review Items scoring less than 95% may only be appealed by addressing the QRI's in the QIP or POC.

Note: Once the plan of correction is accepted the provider will have 90 days to follow up with evidence indicating that changes have been made as outlined in the POC.

Quality Improvement Plan (QIP)
One (1) out of Nineteen (19) providers did not have any claims disallowed. Their only required follow-up is to submit a Quality Improvement Plan which addresses those Quality Review Items. *The implementation of your QIP should be applied to **all** of the agency programs that are contracted to provide Specialty Mental Health Services Medi-Cal. Please use the Exhibit 5 POC/QIP Template.*

Submit the detailed QIP to the Quality Assurance Office no later than thirty (30) calendar days from the date of issuance of this report. Please include timeframes for completion of objectives. The QIP should be sent vie email to:

Jeffery Sammis Psy.D
jsammis@acbhcs.org
(Do not include client Protected Health Information)

If you feel that PHI information needs to be sent the provider must use the Alameda County Secure Email Message Center. If they have not used this encrypted e-mail service before, you may need to register your e-mail account. Here is the link to log on: https://game-message-portal.com/s/login?b=acgov

REGULATIONS; STANDARDS; POLICIES

The regulations, standards, and policies relevant to this Audit include, but are not limited to, the following:

- CA Code of Regulations, Title 9
- DHCS Reasons for Recoupment For FY 2015-2016
- Centers for Medicare & Medicaid Services
- Alameda County Behavioral Health Plan
    - Alameda County Behavioral Health Care Services Clinical Documentation Standards Manual (v. 12/3/14)
    - ACBHCS CQRT Regulatory Compliance Tools (v. 4/15/15)

LIST OF EXHIBITS

Exhibit 1a: Adults' Claim Review Spreadsheet
Exhibit 1b: Children's Claim Review Spreadsheet
Exhibit 1c: Day Rehabilitation Claim Review Spreadsheet
Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for FY 2015-2016
Exhibit 3: Quality Review Spreadsheet
Exhibit 4: Quality Review Key
Exhibit 5: POC/QIP Template

ADDENDUM

Provider P10/ Client C8

1. Number of Quality Items to be addressed in Plan of Correction. 21

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 11, 12, 13, 19, 20, 30, 21, 33, 34, 37, 38, 39, 40, 44, 59, 62, 67, 70, 74, 84, 98

3. Quality Improvement Plan Required: No

4. Claims Compliance: 46%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report):
   Item Number: 6a, 10c, 17a, 17e, 19a(1), 19a(6)

6. Number of claims disallowed: 7 for the audit period

7. Amount of claims to be recouped from the audit period: $1,552.10

8. Number of claims disallowed: 2 outside the audit period

9. Amount of claims to be recouped from outside the audit period: $342.90

10. Total Amount of claims to be recouped: $1,895.00.

11. Plan of Correction Needed: Yes

Provider P16/ Client C14 & C15

1. Number of Quality Items to be addressed in Plan of Correction: 33

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 12, 13, 14, 15, 16, 17, 19, 20, 21, 24, 27, 29, 30, 31, 39, 33, 35, 36, 37, 38, 39, 40, 42, 45, 46, 62, 72, 73, 74, 75, 77, 98, 107

3. Quality Improvement Plan Required: No

4. Claims Compliance: 45%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report):
   Item Number: 1b, 2b, 3b, 4b, 5a, 5b, 5c, 19a(1)

6. Number of claims disallowed: 12 for the audit period

7. Amount of claims to be recouped from the audit period: $4,015.16

8. Number of claims disallowed: 2 outside of the audit period

9. Amount of claims to be recouped from outside the audit period: $748.02

10. Total amount of claims to be recouped: $4,763.18

11. Plan of Correction Needed: Yes

Provider P2/ Client C2

1. Number of Quality Items to be addressed in Plan of Correction: 24

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 14, 15, 16, 17, 20, 31, 32, 33, 34, 37, 44, 45, 46, 62, 65, 67, 68, 70, 89, 92, 93, 98, 101, 107

3. Quality Improvement Plan Required: No

4. Claims Compliance: 0%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report):
   Item Number: 7a, 10a, 10c, 19a(1), 19a(6), 19a(8)

6. Number of claims disallowed: 20

7. Amount of claims to be recouped: $9,721.39

8. Plan of Correction Needed: Yes

Provider P7 and P7-A/ Client C5 and C19

1. Number of Quality Items to be addressed on Plan of Correction: 71

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 27, 29, 30, 31, 33, 34, 35, 36, 37, 38, 40, 44, 45, 46, 51, 52, 59, 61, 62, 63, 64, 66, 67, 68, 69, 70, 71, 72, 74, 76, 77, 78, 80, 81, 82, 83, 84, 85, 88, 89, 90, 91, 92, 93, 94, 96, 97, 98, 99, 105, 110, 114, 119, 120, 121, 122, 124, 125

3. Quality Improvement Plan Required: No

4. Claims Compliance: 21%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report):
   Item Number: 1b, 2b, 3b, 4b, 5a, 6a, 6b, 9a, 17b, 17c, 19a(1), 19a(6), 19a(10), 19a(11), 19a(12), 19a(13)

6. Number of claims disallowed: 42

7. Amount of claims to be recouped: $8,298.12.

8. Plan of Correction Needed: Yes

Provider P12/ Client C10 and C13

1. Number of Quality Items to be addressed on Plan of Correction: 33

2. The Quality non-compliance reasons (Exhibit 2: Quality Review Key): Quality Review Items: 11, 12, 13, 20, 22, 23, 24, 27, 28, 30, 31, 33, 34, 37, 38, 39, 40, 48, 50, 62, 65, 67, 68, 69, 72, 73, 91, 92, 93, 98, 99, 105, 107

3. Quality Improvement Plan Required: No

4. Claims Compliance: 45%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 1b, 2b, 3b, 4b, 10a, 10c, 19a(6)

6. Number of claims disallowed: 6

7. Amount of claims to be recouped: $2,244.75

8. Plan of Correction Needed: Yes

Provider P18/ Client C16

1. Number of Quality Items to be addressed on Plan of Correction: 29

2. The Quality non-compliance reasons (Exhibit 2: Quality Review Key): Quality Review Items: 12, 13, 14, 15, 16, 20, 21, 22, 27, 29, 30, 31, 37, 38, 39, 40, 42, 45, 46, 47, 48, 50, 62, 65, 67, 69, 95, 105, 108

3. Quality Improvement Plan Required: No

4. Claims Compliance: 92%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report):
   Item Number: 10c, 19a(1)

6. Number of claims disallowed: 2

7. Amount of claims to be recouped: $862.95

8. Plan of Correction Needed: Yes

Provider P20/ Client C20

1. Number of Quality Items to be addressed on Plan of Correction: 21

2. The Quality non-compliance reasons (Exhibit 2: Quality Review Key): Quality Review Items: 11, 12, 13, 20, 21, 29, 30, 31, 34, 35, 38, 45, 46, 49, 50, 76, 77, 78, 92, 105, 125

3. Quality Improvement Plan Required: No

4. Claims Compliance: 0%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report):
   Item Number: 15a, 19a(13)

6. Number of claims disallowed: 22

7. Amount of claims to be recouped: $1,909.16.

8. Plan of Correction Needed: Yes

Provider P21 and P21-A/ Client C21 and C22

1. Number of Quality Items to be addressed in Plan of Correction: 28

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 12, 13, 20, 21, 29, 30, 31, 32, 34, 35, 51, 52, 74, 77, 92, 93, 98, 100, 101, 105, 114, 115, 116, 117, 119, 120, 122, 125

3. Quality Improvement Plan Required: No

4. Claims Compliance: 0%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report):
    a. Item Number: 19a(10), 19a(11), 19a(12), 19a(13)

6. Number of claims disallowed: 87

7. Amount of claims to be recouped: $5,862.45

8. Plan of Correction Needed: Yes

Provider P19/ Client C18

1. Number of Quality Items to be addressed in Plan of Correction: 18

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 12, 13, 14, 20, 21, 24, 29, 31, 34, 35, 37, 40, 44, 50, 62, 70, 72, 105

3. Quality Improvement Plan Required: No

4. Claims Compliance: 0%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 7a, 19a(2)

6. Number of claims disallowed: 13 for the audit period

7. Amount of claims to be recouped from the audit period: $2,664.38

8. Number of claims disallowed: 3 outside the audit period

9. Amount of claims to be recouped from outside the audit period: $814.74

10. Total amount of claims to be recouped: $3,479.12

11. Plan of Correction Needed: Yes

Provider P14 and P14-B/ Client C10 and C17

1. Number of Quality Items to be addressed in Plan of Correction: 48

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 62, 70, 72, 74, 78, 81, 84

3. Quality Improvement Plan Required: No

4. Claims Compliance: 47%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 1b, 2b, 3b, 4b, 5a, 5c, 6c, 12, 17e, 19a(1), 19a(6)

6. Number of claims disallowed: 18 for the audit period

7. Amount of claims to be recouped from the audit period: $4,031.72

8. Number of claims disallowed: 1 for outside the audit period

9. Amount of claims to be recouped from outside the audit period: $54.80

10. Total amount of claims to be recouped: $4,086.52

11. Plan of Correction Needed: Yes

Provider P3/ Client C3

1. Number of Quality Items to be addressed in Plan of Correction: 21

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 11, 14, 15, 16, 17, 20, 21, 29, 30, 31, 32, 34, 37, 38, 44, 45, 46, 58, 59, 74, 97

3. Quality Improvement Plan Required: No

4. Claims Compliance: 0%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 5a, 7a

6. Number of claims disallowed: 27 for the audit period

7. Amount of claims to be recouped from the audit period: $4,069.35

8. Number of claims disallowed: 13 outside the audit period

9. Amount of claims to be recouped from outside the audit period: $1,131.75

10. Total amount of claims to be recouped: $5,201.10

11. Plan of Correction Needed: Yes

Provider P17/ Client C16

1. Number of Quality Items to be addressed in Plan of Correction: 23

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 19, 29, 30, 31, 34, 36, 37, 38, 39, 40, 45, 46, 51, 52, 58, 59, 64, 67, 68, 74, 92, 93, 105

3. Quality Improvement Plan Required: No

4. Claims Compliance: 77%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 5b, 10c

6. Number of claims disallowed: 14

7. Amount of claims to be recouped: $2,900.50

8. Plan of Correction Needed: Yes

Provider P6/ Client C5

1. Number of Quality Items to be addressed in Plan of Correction: 14

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 20, 30, 31, 32, 33, 37, 40, 44, 47, 59, 72, 92, 93, 107

3. Quality Improvement Plan Required: No

4. Claims Compliance: 100% (for the audit period)

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): There were no claims disallowed for the audit period. The claims outside of the audit period were disallowed for the following items: 1b, 2b, 3b, 4b, 5d, 7a

6. Number of claims disallowed: 0 for the audit period

7. Amount of claims to be recouped from the audit period: $0

8. Number of claims disallowed: 11 outside of the audit period

9. Amount of claims to be recouped from outside the audit period: $2,127.15

10. Amount of claims to be recouped: $2,127.15

11. Plan of Correction Needed: Yes

Provider P13/ Client C10

1. Number of Quality Items to be addressed in Plan of Correction: 19

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 14, 15, 16, 17, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 31, 33, 62, 77, 92

3. Quality Improvement Plan Required: No

4. Claims Compliance: 33%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 1c, 2c, 3c, 4c, 19a(1)

6. Number of claims disallowed: 2

7. Amount of claims to be recouped: $69.96

8. Plan of Correction Needed: Yes

Provider P4, and P4-A/ Client C4 and C11

1. Number of Quality Items to be addressed in Plan of Correction: 31

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 11, 12, 13, 21, 22, 23, 28, 29, 34, 35, 36, 37, 39, 40, 41, 42, 44, 48, 59, 62, 64, 65, 67, 72, 73, 74, 75, 80, 92, 93, 108

3. Quality Improvement Plan Required: No

4. Claims Compliance: 61%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 5b, 6a, 10c, 14b, 19a(1)

6. Number of claims disallowed: 49

7. Amount of claims to be recouped: $7,666.79

8. Plan of Correction Needed: Yes

Provider P15/ Client C12

1. Number of Quality Items to be addressed in QIP: 8

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 20, 21, 28, 29, 30, 31, 39, 105

3. Quality Improvement Plan Required: Yes

4. Claims Compliance: 100%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: N/A

6. Number of claims disallowed: 0

7. Amount of claims to be recouped: $0

8. Plan of Correction Needed: No

Provider P1 and P1-A/ Client C1and C9

1. Number of Quality Items to be addressed in Plan of Correction: 42

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 12, 13, 14, 15, 16, 17, 18, 20, 21, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 40, 44, 45, 46, 47, 48, 59, 60, 62, 64, 67, 68, 70, 72, 74, 82, 84, 88, 98, 99, 104, 107, 108

3. Quality Improvement Plan Required: No

4. Claims Compliance: 24%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 6a, 6b, 7a, 10a, 10c, 13b, 17e, 19a(1), 19a(6)

6. Number of claims disallowed: 16 for the audit period

7. Amount of claims to be recouped from the audit period: $6,181.20

8. Number of claims disallowed: 28 outside the audit period

9. Amount of claims to be recouped from outside the audit period: $21,638.55

10. Total amount of claims to be recouped: $27,819.75

11. Plan of Correction Needed: Yes

Provider P20/ Client C9

1. Number of Quality Items to be addressed in Plan of Correction: 16

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 21, 28, 29, 31, 35, 37, 38, 62, 67, 68, 70, 74, 82, 89, 92, 93

3. Quality Improvement Plan Required: No

4. Claims Compliance: 60%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 5a, 10a, 10c, 13b, 19a(1), 19a(6), 19a(8)

6. Number of claims disallowed: 4

7. Amount of claims to be recouped: $2,144.50

8. Plan of Correction Needed: Yes

Provider P8, P8-A, and P8-B/ Client C7, C10, and C14

1. Number of Quality Items to be addressed in Plan of Correction: 47

2. The Quality non-compliance reasons (Exhibit 4: Quality Review Key): Quality Review Items: 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 44, 45, 46, 47, 49, 50, 61, 62, 68, 69, 72, 74, 78, 83, 92, 93, 98, 99, 107, 108

3. Quality Improvement Plan Required: No

4. Claims Compliance: 23%

5. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Number: 1b, 2b, 3b, 4b, 5a, 5d, 6a, 6b, 6d, 7a, 9a, 10a, 19a(1)

6. Number of claims disallowed: 40 for the audit period

7. Amount of claims to be recouped for the audit period: $4,417.92

8. Number of claims disallowed: 98 outside the audit period

9. Amount of claims to be recouped from outside the audit period: $23,191.52

10. Total amount of claims to be recouped: $36,536.36

11. Plan of Correction Needed: Yes