alameda county behavioral health

MENTAL HEALTH & SUBSTANCE USE SERVICES

Specialty Mental Health System of Care Audit

Audit Performed in the 3rd Quarter of FY 2021/2022
Audit Period: January 1, 2022 to March 31, 2022

Report Finalized January 10, 2024

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Introduction

The ACBH Quality Assurance (QA) Division completes annual audits of the Specialty Mental Health Services (SMHS) Systems of Care. An audit of the SMHS system of care has been completed by the QA Division for the audit period Q3 2021/2022. At the time of issuance of this report, each provider has received their individualized Audit Findings Report detailing their audit results, required follow-ups, and individualized Corrective Action Plan (CAP) or Quality Improvement Plan (QIP) templates, listing items to be addressed. Appeal information was shared with providers and all appeals have been reviewed and resolved by the QA Division and notification sent to providers. Where QIPs, CAPs or recoupments were necessary, the QA Division has been working with individual providers and internal ACBH teams (e.g., Finance) to follow up, as appropriate.

This report is an aggregate analysis of the findings and rates of compliance with documentation standards, inclusive of disallowances, established by Department of Health Care Services (DHCS), for services claimed to Medi-Cal. In cases where a disallowance is identified, additional claims outside the audit period may also be subject to recoupment.

General Methodology

The QA Division selects a random sample of all submitted SMHS or DMC-ODS claims for Adult/Older Adult and Child/Young Adult Medi-Cal beneficiaries, for the audit period, from the ACBH Medi-Cal claiming system. Selected charts are reviewed for compliance with Medi-Cal claiming requirements and quality of care documentation standards.

The following Quality Review Item (QRI) categories are evaluated during an audit: Screening, Informing Materials, Assessments, Client Plans, Special Needs, Medication Consents and Log (if applicable), Progress Notes, Chart Maintenance, Day Rehabilitation/Day Treatment (if applicable).

QRIs are evaluated from either a categorical (Yes/True = 100%, No/False = 0%) or stratified approach. The stratified approach allows for a more nuanced evaluation of documentation compliance. For example, the stratified approach is used for the QRI evaluating whether a Progress Note exists for every service contact. For this item, if ten (10) claims were submitted and only eight (8) Progress Notes documented in the chart, the item would be scored as 80% compliant.

QRIs are inclusive of reasons for claims disallowances but not all QRIs result in disallowance and recoupment. The attached *Quality Review Key* provides QRI descriptions and details.
QRIs that do not apply to specific charts, such as when clients do not receive medication support services, are scored as N/A and are not incorporated into the final score for that QRI.

Audit Results

This audit involved review of charts for **Quarter 3, FY 2021/2022** and dates of service **January 1, 2022 through March 31, 2022**. Ten (10) providers, ten (10) charts, five (5) from each Child/Young Adult and Adult/Older Adult systems, and 255 claims were reviewed for this audit.

There were no claims disallowances identified during this audit. The overall compliance rate for Quality Review Items across all charts was 96%, compared to 90% during the same quarter in 2021.

On December 10, 2021, DHCS released Behavioral Health Information Notice (BHIN) No: 21-073. This BHIN resulted in significant changes effective January 1, 2022 including the following:

- Change to the access criteria for outpatient services.
- Allowing services to be provided prior to determination of a diagnosis, without completion of a treatment plan, and when there is a co-occurring substance use disorder.
- Elimination of the Included Diagnosis List.

The cases reviewed for this audit were evaluated based on these new requirements. The following tables provide additional details related to the audit findings.

Table #1. Disallowances by Dollar Amount		
Claim Status	**Claims Reviewed**	**Dollars**
Allowed	255	$85,196.70
Disallowed	0	$0
Total Q3 2022	255	$85,196.70

Table #2. Disallowances by Population			
Provider Type	**Number of Claims Reviewed**	**Disallowed Claims**	**Dollars**
Child/Young Adult	182	0	$0
Adult/Older Adult	73	0	$0
All	255	0	$0

The overall compliance rate across all charts ranged from 91% to 98%, with Child/Young Adult provider scores ranging from 96% - 98% and Adult/Older Adult scores ranging from 91-98%.

Table #3. QRI Compliance by Population			
Number of Charts- Child/Young Adult	**Number of Charts- Adult/Older Adult**	**Quality Compliance Range**	**Percentage**
4	4	95% - 100%	80%
1	1	90% - 94%	20%
0	0	<90%	0%

Table #4. QRI Compliance by Category	
Categories	**Compliance %**
Informing Materials	90%
Medical Necessity & Access	100%
Assessment	96%
Client Plan	90%
Special Needs	96%
Medication Logs, Consents and E/M Notes	100%
Progress Notes	98%
Chart Maintenance	95%

Table #5. Comparison of Current to Previous Results		
Audit Period	**Disallowance Rate**	**Compliance Rate**
Q3 FY 21-22	0	96%
Q3 FY 20-21	25%	90%

Summary and Next Steps

Overall, the audit findings were very positive across the charts that were reviewed and a significant improvement from the audit result from the same quarter in the previous fiscal year. For the QRIs that were found to be non-compliant, the following common issues were identified:

- Late entry of Progress Notes, beyond 5 business days. Effective July 1, 2022, CalAIM Documentation Redesign changed this requirement to 3 business days for routine and 24 hours for crisis notes.
- Missing or incomplete medication information, specifically prescriber identifying information, and past medication.
- Missing medical conditions.
- Incomplete documentation of relevant cultural issues. Although general information about language and ethnicity were noted, more in depth analysis of the cultural issues and their incorporation into the clinical formulation was lacking.
- Documenting beneficiary participation and agreement with Client Plan. Effective July 1, 2022, this is no longer a requirement.
- Documenting emergency contact information where it is prominently displayed in the chart.

Individual provider Quality Improvement Plans addressing the above issues were reviewed by QA. Examples of plans included improving clinical note templates in Electronic Health Records to better capture the required information, training and re-training of staff, and more frequent

review of charts using the Clinical Quality Review Team (CQRT) tool to ensure compliance with these items.

For more details related to the specific data or if you have any questions related to this audit and its findings, please contact QA.Audits@acgov.org.

Sincerely,

Torfeh Rejali, LMFT

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Division Director, Quality Assurance

cc: Karyn Tribble, ACBH Director
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References

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 2021-2022
- CalMHSA Clinical Staff Documentation Guide

Attachments

Quality Review Key