System of Care Audit of Contracted Substance Use Disorder Service Organizations

Audit Performed in 4th Quarter of 2019
For Audit Period: January 1, 2019 – March 31, 2019

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INTRODUCTION

This audit reviewed a sample of charts relevant to substance use service claims made during the period of January 1, 2019 to March 31, 2019 to *Alameda County Behavioral Health (ACBH)* by its subcontracted substance use disorder service providers. The purpose of this report is to describe common documentation standards concerns identified during the audit and to report out on the rates of compliance with *ACBH Substance Use Disorder (SUD) Services* documentation standards.

This report provides feedback regarding documentation strengths as well as training needs for ACBH SUD programs and services across the system of care. Since the audit period was in the first year of the Alameda County Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver reorganization, charts for this audit were selected to maximize the potential for useful feedback for our providers. Providers are expected to utilize specific chart comments/feedback and extrapolate findings across all their programs.

The ACBH Quality Management Director determined that each agency would submit one chart (with services during the audit period) for audit review. A total of eight-hundred and one (801) claims were audited from eighteen (18) unique charts. An additional chart was audited for a provider that, at the time of this report, had not yet claimed for services. Results from that chart were not factored into this report. All claims were reviewed for compliance and quality of care utilizing standardized chart audit protocols (see *Exhibit 4 – SUD Quality Review Item Key*) based on *ACBH SUD Services Documentation Standards.*

Like other counties, Alameda County SUD treatment services are funded through a variety of sources, including Drug Medi-Cal, SAMHSA Block Grant (SABG), county general funds, AB109, and other funding sources. To create uniformity across the ACBH SUD continuum of care, Alameda County has developed standardized documentation and treatment standards, regardless of the funding. With consideration for the best needs of the clients, all reasonable efforts have been made to hold the full ACBH SUD System of Care (SOC) to the highest standard.

Each chart was reviewed for compliance with Medi-Cal claiming requirements and for ACBH SUD quality of care documentation standards. *(References: ACBH SUD Practice Guidelines* and *ACBH SUD Clinical Documentation Standards Training materials may be found at http://www.acbhcs.org/providers/QA/Training.htm)*

CLAIMS REVIEW RESULTS

The claim amounts presented in this report are best estimates. Questions related to claim or recoupment amounts should be directed to *ACBH Finance Department.*

Overall, of the 801 total claims examined by QA clinical staff, 327 claims (41%) met established documentation standards and 474 claims (59%) were disallowed and deemed non-compliant. See **Table #1: Overall Claims Compliance** below:

Table #1: Overall Claims Compliance			
Number of Claims	Allowed Claims	Disallowed Claims	Percent Compliant
801	327	474	41%

The overall claims compliance of 41% is the same as the Q1 2018 SUD SOC Audit.

The total number of claims reviewed was eight hundred and one (801) with an estimated service cost of $51,566.68. The total number of allowed claims was three-hundred and twenty-seven (327) with an estimated service cost of $21,523.44. The total number of disallowed claims was four-hundred and seventy-four (474) with an estimated service cost of $30,043.24 These 474 claims will be refunded to Medi-Cal as an overpayment of services. Please see **Table #2: Claims Compliance by Estimated Dollar Amount** below.

Table #2: Claims Compliance by Estimated Dollar Amount		
Claims	Number	Amount in Dollars
Total	801	$51,566.68
Total Allowed	327	$21,523.44
Total Disallowed / Refunded to DHCS	474	$30,043.24

The overall claims compliance rate for this audit was found to be 41% (327 of 801 allowed). However, there were variations in compliance by level of care. See **Table #3: Claims Disallowance by Level of Care** below for a breakdown of different service types and their compliance rate for this audit. Note that Opioid Treatment Program (OTP) Dosing claims made up the majority of claims made during the audit period, and when these dosing claims are not factored into the results (because they are a medication dispensing activity), the overall claims compliance rate of SUD treatment services improves slightly to 44%.

Table #3: Claims Disallowance by Level of Care				
Claims	Total	Allowed	Disallowed	Percent Compliant
Outpatient (includes Intensive Outpatient and Recovery Support)	96	50	46	52%
Residential/Withdrawal Management Residential	198	81	117	41%
Opioid Treatment Program (OTP)	507	196	311	39%
OTP Non-Dosing	48	21	27	44%
OTP Dosing	459	175	284	38%
All Non-Dosing	342	152	190	44%

Table #4: Claims Compliance by Chart below groups chart compliance together by range of claims compliance. The *average chart compliance for all disallowance reasons* indicated that 17% of providers (3 of 18) scored in the compliance range of 95% - 100%, 6% of providers (1 of 18) scored in the

compliance range of 85% - 94%, 11% of providers (2 of 18) scored in the compliance range of 75% - 84%, 0% of providers (0 of 18) scored in the compliance range of 65% - 74%, and 67% of providers (12 of 18) scored below 65%.

Table #4: Claims Compliance by Chart		
Number of Providers	Average Chart Compliance %	Percentage of Total
3	95%-100%	17%
1	85%-94%	6%
2	75%-84%	11%
0	65%-74%	0%
12	< 65%	67%

Each claim was reviewed individually for compliance with established requirements, when applicable reasons for disallowance were identified. Some claims, due to overlapping issues of non-compliance, have multiple reasons for disallowance. When reasons for all claims disallowances are grouped into like categories, the results are as follows:

<u>Sixteen percent (16%) of the reasons for disallowance were related to medical necessity not being established:</u>

Under DMC-ODS, medical necessity is established through three primary components; 1) Establishment by a LPHA of an included SUD diagnosis; 2) Determination of an ASAM Level of Care (LOC) by trained staff, and that; 3) Services are in accordance with provisions outlined in 22 CCR § 51303. Non-compliance with medical necessity requirements may result in multiple claims being disallowed, depending on the timing of the issue. Note that beneficiaries receiving services at OTPs have additional specific medical necessity requirements related to physical dependence on opioids and prior treatment attempts.

<u>Forty percent (40%) of the reasons for disallowance were due to non-compliance with intake/assessment requirements:</u>

DMC-ODS requires that a comprehensive biopsychosocial assessment be completed for every beneficiary. The 10 required categories of assessment identified in the DMC-ODS Intergovernmental Agreement (IA) are: drug/alcohol history, medical history, family history, psychiatric/psychological history, social/recreational history, financial status/history, educational history, employment history, criminal history/legal status, and previous SUD treatment history. The IA also defines intake as including, "the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services." For assessment components where it is not clinically appropriate to gather the required information, providers are instructed to indicate the reason why and that this information will continue to be assessed as clinically appropriate. Information necessary to establish medical necessity for substance use treatment services is always required. Non-compliance with intake/assessment requirements may result in multiple claims being disallowed, depending on the timing of the issue.

Nineteen percent (19%) of the reasons for disallowance were related to the Client Plan requirements not being met:
For SUD services, both planned and unplanned services may be provided prior to the initial plan being completed and before the initial plan due date of the level of care (LOC), whichever date is earlier. Once the initial client plan has been completed, only unplanned service types and the planned service types identified in the current plan are allowed for claiming. If a client plan is completed late, no services may be claimed until the plan has been completed. Depending on the timing of the issue, non-compliance with client plan requirements may result in multiple claims being disallowed.

Twelve percent (12%) of the reasons for disallowance were related to progress note requirements not being met:
Progress notes document progress in treatment, progress on treatment plan goals, and are associated with each claim. In the ACBH SUD SOC, progress notes may be for individual services (such as an individual session at an Outpatient Service provider), a daily note (such as note documenting a residential day), a weekly summary (a non-billable progress note for residential providers but may result in daily residential claim disallowances when non-compliant), and non-claimed informational only notes. Non-compliant progress notes usually only result in the claim related to that note being disallowed; except for the weekly summary which may result in multiple residential days being disallowed. Because informational only notes are not associated with any claims, they are only typically reviewed when they provide information and context for claimed services.

Ten percent (10%) of the reasons for disallowance were related to OTP specific requirements not being met:
Opioid Treatment Programs (OTPs) are regulated by a complex framework and have several additional requirements. Under DMC-ODS, OTPs are required to operate under the provisions set forth in the IA which includes multiple references to 9 CCR § Ch. 4. For this audit disallowances related to OTP specific services were determined largely by non-compliance with 9 CCR § Ch. 4 requirements.

Several other categories, such as Withdrawal Management (WM) 3.2, Groups, Perinatal, Adolescent, Discharge, and Chart/Agency were examined as well, and each represented 1% or less of all disallowance reasons.

Table #5 Reasons for Claims Disallowances below categorizes the reasons for claims disallowances:

Table #5 Reasons for Claims Disallowances		
Reasons Category	Quality Review Items (QRI)	Percent of Disallowance Reasons
Medical Necessity	6-17	16%
Intake/Assessment	18-38	40%
Client Plan	39-55	19%
Progress Notes	56-82	12%
Residential Progress Notes	83-89	1%
WM 3.2 Requirements	90-92	<1%
Groups	93-100	<1%

Perinatal Requirements	101-107	1%
Adolescent Requirements	108-113	N/A
OTP Only Requirements	114-148	10%
Discharge	149-160	N/A
Chart/Agency	161-178	<1%

Information on the number and percentages of claims for each service type are listed below in descending frequency based on the percent allowed. This information is intended to show the compliance rate of particular service types in order to identify specific areas of strength and for improvement within the SUD SOC. Data in this table indicates room for significant improvement in documentation of every service type. SUD residential treatment includes many of these treatment services, but as those services are bundled into one service code, that information is presented in other parts of this report (Table #3). For information described in this section of the report, see **Table #6: Information of Individual Service Types** below:

Table #6: Information of Individual Service Types				
SUD Service Type	**Total Claims**	**Total Allowed**	**Total Disallowed**	**Percent Allowed**
Group Patient Education	3	3	0	100%
Intake/Assessment	10	7	3	70%
Case Management	6	4	2	67%
Treatment Planning	6	3	3	50%
Collateral	2	1	1	50%
Group Counseling	60	30	30	50%
Individual Counseling	55	24	31	44%
Family Therapy	1	0	1	0%
Individual Patient Education	2	0	2	0%
Discharge Services	0	0	0	N/A
Physician Consultation	0	0	0	N/A
SUD Crisis	0	0	0	N/A

Given that this audit occurred during the first year implementation of the Alameda County DMC-ODS, ACBH Quality Management leadership decided to provide potentially useful feedback to our providers and limited disallowances to issues primarily related to medical necessity.

The total amount of disallowances resulted in a total of 331 claims being recouped from ACBH providers, with an amount of $13,416.43.

QUALITY REVIEW

The Quality Review determined if the standards for documentation of DMC-ODS had been met. Fifteen (15) quality review areas, with 186 total Quality Review Items (QRIs), were analyzed in this audit. They included: *Informing Materials, Medical Necessity, Medical/Health, Intake/Assessment, Client Plans,*

Progress Notes, Residential Services, Groups, Withdrawal Management, Perinatal Services, Adolescent Services, Opioid Treatment Program Services, Discharge Services, Chart, and Agency-Specific services.

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

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 (or Exhibit 4) 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 #56 "There is a note for each claim?"*:
    - *If there were 10 claims made during the audit period and 8 progress notes 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 QRIs do not apply to specific charts, such as when clients do not receive opioid treatment 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 SOC Quality Review Results and are not considered in 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 SUD 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.

The overall compliance rate for the Quality Review was 75% (see Exhibit 3). The results of the Quality Review for eighteen (18) charts demonstrated that 0% (0 of 18) of the charts scored in the 95% - 100% range, 44% (8 of 18) of the charts scored in the 85% - 94%, 28% (5 of 18) of the charts scored in the 75% - 84% range, 11% (2 of 18) of the charts scored in the 65% - 74% range, and 17% (3 of 18) of the charts scored below 65%. See **Table #7: Quality Review Compliance by Chart** below:

Table #7: Quality Review Compliance by Chart		
Number of Charts	Quality Compliance Rate	Percentage
0	95% – 100%	0%
8	85% – 94%	44%
5	75% – 84%	28%
2	65% – 74%	11%
3	<65%	17%

Table #8: Provider QRI by Category below provides information about percentages of quality item compliance across all charts audited when grouped into categories of similar items. The leftmost column lists the group category; see Exhibit 3: SUD *SOC Quality Review Item Results* for a complete listing of all the QRIs that comprise each category. The rightmost column shows the percentage of claims disallowed by QRI. When present, N/A indicates there were no relevant QRIs for that item.

Table #8: Provider QRI by Category	
Category Description	% Compliant
Informing Materials	65%
Medical Necessity	79%
Medical / Health	85%
Intake Assessment	75%
Client Plan	65%
Progress Notes	84%
Residential Progress Notes	87%
WM 3.2	0%
Group Services Progress Notes	87%
Perinatal Services	50%
Adolescent Services	67%
OTP Specific (9 CCR § Ch. 4)	90%
Discharge	0%
Chart Overview	60%
Agency	50%

Each of the items reviewed for this audit are described below, along with compliance percentages across all charts audited. For categorical (yes/no) QRIs, both the average percent compliant and frequency of chart compliance is provided. For stratified questions, only the average percent complaint is able to provided, as each relevant chart may have different numbers of items reviewed for that QRI.

Consents/Informing Materials

- 56% (10/18) of the charts had an up to date and accurate InSyst Face Sheet, including RU, EOD, and SUD included diagnosis. QRI#1.

- 70% (7/10) of the charts had valid ACBH Authorization and/or required CQRT that covered the audit period. QRI#2.
- 61% (11/18) of the charts had a current and signed ACBH Informing Materials/Consent to Treat signature page prior to the Intake/Assessment completion date and then reviewed annually. QRI#3.
- 72% (13/18) of the charts had a SUD Programs ROI by the opening date of services. QRI#4.
- 71% (5/7) of the charts that prescribed medications reflected a signed Medication Consent/Informed Consent for the medications prescribed. QRI#5.

Medical Necessity

- 83% (15/18) of the charts had the required relevant medical necessity documents (e.g. Initial Medical Necessity (IMN)/Continuing Service Justification (CSJ) for services provided during the audit period and were completed on-time. QRI#6.
- 89% (16/18) of the charts had allowable SUD diagnoses for treatment. QRI#7.
- 78% (14/18) of the charts had, for the SUD diagnoses being treated, the minimum number of DSM-5 symptoms required for the diagnosis. QRI#8.
- 72% (13/18) of the charts included, for the SUD diagnoses being treated, the timeframes and symptoms of the diagnoses. QRI#9.
- 78% (14/18) of the charts included, for the SUD diagnoses being treated, the written basis for the diagnosis was individualized (for at least the minimum number of symptoms for that diagnosis). QRI#10.
- 78% (14/18) of the charts indicated that, for the SUD diagnoses being treated, the diagnosis(es) were established by a LPHA. QRI#11.
- 92% (12/13) of the charts demonstrated that the LPHA establishing the SUD included diagnosis met face-to-face or via telehealth with the beneficiary or SUD counselor who conducted the intake assessment (for initial) or primary SUD counselor (for CSJ). QRI#12.
- 92% (11/12) of the charts indicated that all the additional medical necessity requirements (questions a-e and LPHA attestation) on the relevant IMN or CSJ forms were met. QRI#12A.
- 78% of the ALOC(s) relevant to review period were completed within required time frame. QRI#13.
- 76% of the ALOC(s) relevant to the review period were completed by staff with the credentials to do so. QRI#13A.
- 67% (12/18) of the charts had ALOCs included descriptions for all pertinent elements. QRI#14.
- 75% of the indicated ASAM LOC matched client's presentation at the time of completion. QRI#15.
- 80% of the ALOC(s) included documentation of the reason a referred LOC was different than assessed/indicated the LOC, when required. QRI#16.

- N/A. The charts included a completed Continued Justification of Services, when required. QRI#17.

Medical / Health Assessment

- 94% (16/17) of the charts met physical exam requirements. QRI#18.
- 60% (3/5) of the charts included documentation of the agency's MD/NP/PA review of physical exams completed by an external health provider. QRI#19.
- 78% (14/18) of the charts noted allergies/adverse reactions/sensitivities or lack thereof prominently on charts' cover or in EHR. QRI#20.
- 92% (11/12) of the charts included completed Health Questionnaire (must include minimum information from DHCS 5103) when required. This is a requirement for AOD certified/licensed programs. QRI#21.

Intake/Assessment

- 72% (13/18) of the charts included Intake/Assessment completed within required time frames. QRI#22.
- 89% (16/18) of the charts included an assessment of the beneficiary's previous SUD treatment history (or a valid reason why not/plan to assess in the future given). QRI#23.
- 67% (12/18) of the charts included an assessment of the beneficiary's drug/alcohol use history. QRI#24.
- 89% (16/18) of the charts included an assessment of the beneficiary's medical history (or a valid reason why not/plan to assess in the future given). QRI#25.
- 78% (14/18) of the charts included an assessment of the beneficiary's psychiatric/psychological history (or a valid reason why not/plan to assess in the future given). QRI#26.
- 78% (14/18) of the charts included an assessment of the beneficiary's family/social/recreational history (or a valid reason why not/plan to assess in the future given). QRI#27.
- 61% (11/18) of the charts included an assessment of the beneficiary's financial status/history (or a valid reason why not/plan to assess in the future given). QRI#28.
- 89% (16/18) of the charts included an assessment of the beneficiary's educational history (or a valid reason why not/plan to assess in the future given). QRI#29.
- 72% (13/18) of the charts included an assessment of the beneficiary's employment history (or a valid reason why not/plan to assess in the future given). QRI#30.
- 78% (14/18) of the charts included an assessment of the beneficiary's criminal history and legal status (or a valid reason why not/plan to assess in the future given). QRI#31.
- 56% (10/18) of the charts included an assessment of the beneficiary's risks [e.g. relapse, Danger to Others (DTO)/Danger to Self (DTS)]. QRI#32.

- 72% (13/18) of the charts gathered the beneficiary's SOGIE (Sexual Orientation, Gender Identify/Expression) information (or indicated plan to assess). QRI#33.
- 83% (15/18) of the charts assessed beneficiary's language preference at intake. QRI#34.
- 83% (15/18) of the charts included an Intake/Assessment completed by a staff with the credentials to do so and within their scope of practice/training at the time of the assessment. QRI#35.
- 75% (12/16) of the charts included documentation that required reviews of the Intake/Assessment document were completed on-time (as indicated by complete co-signatures). QRI#36.
- 61% (11/18) of the charts included a detailed formulation based on the intake/assessment. QRI#37.
- N/A. The charts updated the Intake/Assessment document when applicable. QRI#38.

<u>Client Plan</u>

- 65% of the client plan(s) addressed or deferred (with explanation) all the challenges identified in the intake/assessment. QRI#39.
- 79% of the client plan(s) included goals to be reached that addressed each non-deferred challenge (or problem). QRI#40.
- 79% of the client plan(s) included goals/action steps that were consistent with impairment to functioning and need for SUD treatment. QRI#41.
- 29% of client plan(s) included specific, measurable, attainable, realistic, observable (SMART) action steps. Target dates are also required for each objective/action step. QRI#42.
- 68% of client plan(s) included service descriptions (type of counseling) and frequency. QRI#43.
- 67% of client plan(s) included the ICD-10 code and DSM-5 name of diagnosis. QRI#44.
- 85% of the client plan(s) were consistent with diagnosis and medical necessity (golden thread). QRI#45.
- 64% of client plan(s) included goals for treatment when the physical exam indicated significant illness. QRI#46.
- 32% of required safety plan(s) addressed client risk (relapse, DTS/DTO, at risk for DV/IPV, Abuse, etc.) and included follow-up. QRI#47.
- 71% of client plan(s) indicated who is client's "primary" counselor/LPHA. QRI#48.
- 50% of client plan(s) were revised when significant change occurred (e.g. in service, diagnosis, focus of treatment, inaccurate frequency, etc.). QRI#49.
- 64% (9/14) of charts indicated evidence of Coordination of Care, when applicable. QRI#50.
- 65% of client plan(s) were individualized and used language the client will understand. QRI#50A.
- 29% of client plan(s) contained a tentative discharge plan. QRI#51.

- 79% of charts had client plan(s) that included the complete signature of plan author (LPHA or Counselor). QRI#52.
- 68% of client plan(s) relevant to the review period were completed on time. QRI#53.
- 74% of client plan(s) were signed/dated by client (or legal representative when appropriate) or documentation of client refusal or unavailability within required time frames. QRI#54.
- 75% of client plan(s) were co-signed by all required staff within required time frame. QRI#55.

Progress Notes General

- 95% of claims had required progress notes. Residential providers are required to have a daily note documenting the full days' worth of services and a weekly summary if a daily narrative was not completed. Additionally, OTP dispensing claims are documented on a log and do not require an individual service note. All other services, including case management, require individualized progress notes. QRI#56.
- 91% of progress notes included dates for each required aspect of the service. QRI#57.
- 90% of progress notes indicated location of service: in-person, telephone, telehealth. QRI#58.
- 87% of progress notes included info on the beneficiary's attendance, including start and end times of each service. QRI#59.
- 82% of progress notes documented face-to-face, travel, and total times. QRI#60.
- 92% of progress notes included the topic or purpose of the session. QRI#61.
- 81% (13/16) of charts had progress notes indicating that the services provided were generally consistent with the frequency of services identified in the plan for the time-period of the plan. QRI#62.
- 88% of progress notes claimed for planned service codes in applicable plan or plans. For SUD services, planned services may be provided prior to the plan due date or plan completion date, whichever is earlier. QRI#63.
- 81% of progress notes used the correct procedure code. Progress notes must have the procedure code or exact name of procedure code. QRI#64.
- 89% of progress notes demonstrated that services were claimed by the individual providing the service. QRI#65.
- 98% of progress notes / services were related to the current client plan goals. QRI#66.
- 77% of progress notes included a description of beneficiary progress on client plan problems, goals, action steps, objectives, and/or referrals. QRI#67.
- 71% of progress notes included client and/or staff follow-up plan. QRI#68.
- 15% of progress notes for services provided in the community indicated how provider ensured confidentiality. QRI#69.
- 71% of progress notes included author's legibly printed name, credentials, signature, and date. QRI#70.

- 89% of progress notes were individualized and with minimal copy/paste. QRI#71.
- 75% of progress notes were completed by due date. QRI#72.
- 85% of progress notes included reasonable documentation time that was substantiated by content. QRI#73.
- 86% of services were provided by allowable staff within their scope of practice. QRI#74.
- 85% of planned services provided utilized one of the allowed Evidence Based Practices (EBPs). QRI#75.
- 85% of services were provided by staff with valid credentials to do so at the time of the service. QRI#76.
- N/A of *Physician Consultation* services were between agency physician and ACBH specified physician consultant. QRI#77.
- 60% of progress notes documented the language that the service was provided in. QRI#78.
- 100% (1/1) of progress noted indicated when interpreter services were used, and relationship to client was indicated, as needed. QRI#79.
- 95% of services provided did not include time claimed for non-billable activities. QRI#80.
- 95% of services were provided while client was not in lock-out setting, jail, Juvenile Hall (youth w/out adjudication). QRI#81.
- 100% (2/2) of IOS charts met minimum/maximum hour requirements or provider followed ACBH IOS frequency policy. QRI#82.

<u>Residential Services</u>

- 96% of residential services had at least one required service documented daily (RES 3.1 > 15 min, RES 3.3/3.5 > 1 hour). QRI#83.
- 80% (4/5) of residential charts, documented at least 20 hours of face-to-face structured therapeutic activities per calendar week or that the provider offered/attempted to provide 20 hours of services per week and the client (due illness or other legitimate clinical reason) was unable to attend. QRI#84.
- 80% (4/5) of residential charts documented the required number of clinical services per week. For ASAM 3.1 at least 5 or ASAM 3.3/3.5 at least 12 hours of face-to-face clinical services documented within at least 5 days during a calendar week. QRI#85.
- 100% (5/5) of residential charts claimed only included RES reimbursable activities. QRI#86.
- 80% (4/5) of the residential charts provided documentation that all licensed residential services, except transportation, occurred within the legal address of the licensed entity. QRI#87.
- QRI#88. Question skipped. N/A.
- N/A. The residential charts documented that transportation time was for providing and coordinating transportation only. QRI#89.

Withdrawal Management 3.2

- 0% (0/1) of the WM 3.2 charts indicated services provided were intake, observation, medication services, care coordination, treatment planning, and discharge services. QRI#90.
- 0% (0/1) of the WM 3.2 charts indicated that observational and physical checks were documented every 30 minutes for the first 72 hours following admission. QRI#91.
- 0% of documentation of observations and physical checks included printed name, signature, credentials, and date. QRI#92.

Group Services

- 90% of group sign-in sheets included the number of participants. QRI#93.
- 86% of group sign-in sheets were present for every group counseling session or group patient education session. QRI#94.
- 71% of group notes included co-facilitator's name, credentials, signature, date, and face-to-face time only. QRI#95.
- 85% of group sign-in sheets included the date and start/end time (if different for client, this is indicated. QRI#96.
- 82% of group sign-in sheets included the topic of the session. QRI#97.
- 86% of group sign-in sheets included the client's legibly printed name & signature. QRI#98.
- 100% (10/10) of charts indicated that adults were not in groups with beneficiaries 17 or younger unless at a certified school site, when required. QRI#99.
- 85% of group sign-in sheets had the legibly printed name, credential, and signature of the SUD Counselor/LPHA who conducted the group. QRI#100.

Perinatal Services

- 100% (2/2) of the charts had additional required perinatal assessment items completed. QRI#101.
- 0% (0/2) of the charts indicated that regularly scheduled UA Screening was documented, "to reduce harm?" QRI#102.
- 50% (1/2) of the charts that included child care services were included in the client plan and/or Wait List. QRI#103.
- 50% (1/2) of the charts included documentation of how child care services addressed therapeutic and developmental needs noted in assessment. QRI#104.
- 50% (1/2) of the charts included *Parenting Skills* and *Relationship Building* in the client plan. QRI#105.
- N/A. The charts documented Referrals to Community Services "Outreach." QRI#106.
- 50% (1/2) of the charts included documentation of beneficiary eligibility for perinatal services. QRI#107.

Adolescent Services

- 100% (2/2) of the charts included an assessment / evaluation of developmental & cognitive functions. QRI#108.
- 0% (0/1) of the charts identified safety issues and included follow-up. QRI#109.
- 50% (1/2) of the charts documented alcohol and drug testing schedule. QRI#110.
- N/A. Intensive Outpatient Service (IOS)/Residential (RES) charts included a client plan including therapeutic (art therapy, writing) & diversionary recreation activities (physical health, stretching, sports). QRI#111.
- 50% (1/2) of the charts had a client plan that included Educational Sessions (i.e. Nutrition, Addiction, HIV/AIDS, TB, STD, Hepatitis). QRI#112.
- 100% (2/2) of the charts included documentation of efforts to involve family or other support persons, including in the client plan. QRI#113.

Opioid Treatment Programs General

- N/A. OTP charts that included requests for exceptions to 9 CCR, Ch. 4 regulations related to claims made during the audit period were completed and documented according to requirements. QRI#114.
- 100% (6/6) of OTP charts indicated that prior to admission, client had the required lab tests: 1) narcotic drug use, 2) tuberculosis, and 3) syphilis; (unless the medical director has determined the applicant's subcutaneous veins were severely damaged to the extent that a blood specimen cannot be obtained). QRI#115.
- 100% (6/6) of OTP charts included documentation that the program completed the required tasks related to detection of multiple registrations prior to admitting the client for treatment. QRI#116.
- 67% (2/3) of OTP charts indicated that, if the client's initial drug test or analysis was positive for Methadone or its metabolite, the program followed the required steps to ensure that the client was not receiving opioid replacement therapy elsewhere. QRI#117.
- 100% (1/1) of OTP charts indicated that, if it was determined that a client was receiving controlled narcotic replacement therapy at another OTP, the provider attempted coordination with the other OTP to ensure only one was providing treatment or that the client had been approved for visiting patient privileges. QRI#118.
- N/A. OTP charts indicated that visiting patient dosing (client visiting from another OTP) during the audit period was done in compliance with requirements. QRI#119.
- N/A. OTP charts indicated that the program responded accordingly to DHCS reports of possible multiple registrations. QRI#120.
- 100% (6/6) of OTP charts included evidence that the prescriber verified the client's controlled substance history using the CURES database as recommended. QRI#121.

- N/A. OTP charts indicated that services provided to youth (17 and under) were in accordance with requirements for parental/guardian approval (or DHCS approved exception). QRI#122.
- 83% (5/6) of OTP charts indicated that the required informing/consent information was provided at intake. QRI#123. See 9 CCR § Ch. 4 for specific requirements.
- 80% (4/5) of OTP charts had client plan updates that included a summary of the client's progress or lack of progress toward each goal identified on the previous plan. QRI#124.
- 100% (2/2) of OTP charts, if occurring during the audit period, included documentation of the initial dose administered or observed by physician or medical director or delegated to another staff within their scope of practice to administer medications. QRI#125.
- 100% of counseling services claims documented one or more of the following elements of the session. QRI#126.
- 83% of OTP dosing records contained at a minimum, accurate records of dates, quantity, and batch code marks of the medications. QRI#127.
- 67% of dosing record/log for claims made during the audit period were signed by staff with the credentials to do so. QRI#128.
- 100% of dosing claims made during the audit period had a corresponding entry in the dosing log. QRI#128A.
- 83% of dosing claims on the claims sheet (*Therapist Name* column) were made either by the physician ordering the medications or the medical staff administering the medications. QRI#129.
- 83% (5/6) of OTP charts included evidence that tests or analyses of illicit drug use were performed as required by 9 CCR, Ch. 4. QRI#129A.
- 67% (4/6) of OTP charts included evidence in the medical record of the program's response to a test or analysis for illicit drug use which disclosed both the absence of methadone and its primary metabolite (when prescribed by the medical director and program physician), the presence of any illicit drugs, or abuse of other substances, including alcohol. QRI#129B.
- 100% of patient record notes completed by the medical director or physician related to the audit period were signed. QRI#130.
- N/A. Of the OTP charts indicated, if the client was discharged for cause during the audit period, that the OTP followed the requirements below and policies outlined in their program protocol. QRI#131.
- N/A. OTP charts for ACBH subcontracted out-of-county (OOC) OTP services, there was documentation in the medical record that demonstrated OOC services are medically necessary. QRI#131A.
- N/A. OTP charts documented that when the client missed three (3) or more consecutive doses of replacement narcotic therapy, the medical director or program physician provided a new medication order before continuation of treatment. QRI#131B.

OTP Maintenance Services

- 100% (6/6) of OTP charts, prior to, or on the day of, admission, included documentation of the client's signs of physical addiction/dependence to opiates by a physician. QRI#132.
- 100% (6/6) of OTP charts, prior to admitting a client to treatment, included documentation of confirmed history of two years of addiction to opiates. QRI#133.
- 83% (5/6) of OTP charts, prior to admitting a client to treatment, included documentation of confirmed history of two or more unsuccessful attempts in withdrawal treatment and subsequent relapse to illicit opiate use. QRI#134.
- 100% (6/6) of OTP charts, prior to admitting a client to treatment, included documentation by a physician of certification of fitness for replacement narcotic therapy based upon physical examination, medical history, and indicated laboratory findings. QRI#135.
- 100% (6/6) of OTP charts documented that between 50 and 200 minutes of counseling services were provided every calendar month of services rendered, unless adjusted or waived by medical director. QRI#136.
- N/A - OTP charts documented that when the client missed 2 weeks or more without notifying the program, they were discharged. QRI#137.
- N/A - OTP charts documented that pregnant women who received maintenance therapy were reevaluated no later than 60 days after the pregnancy ended (birth or otherwise. QRI#138.
- 100% (3/3) of OTP charts included physician or medical director documentation, that in their clinical judgment, the patient was responsible in handling controlled medications. QRI#139.
- 67% (2/3) of OTP charts indicated that when the medical director or program physician placed a client on one of the six take-home medication schedules, all the required criteria were met. QRI#140.
- 100% (3/3) of OTP charts included documentation that the medical director or program physician determined the quantity of take-home medication dispensed to a client. QRI#141.
- 100% (3/3) of OTP charts included documentation that the program instructed each client of their obligation to safeguard the take-home medication. QRI#142.
- 50% (1/2) of OTP charts included documentation that when, during the audit period, the program obtained evidence of any of the concerns described in 9 CCR § 10390, take-home medications were restricted within 15 days. QRI#143.
- N/A - OTP charts included documentation that when take-home medication privileges were restored during the audit period the conditions described in 9 CCR § 10400 were documented by the physician or medical director as being met prior to or on the date of restoration. QRI#144.

OTP Detoxification Services

- N/A - OTP Detoxification services charts indicated that the client met admission criteria for Detoxification services. QRI#145.
- N/A - OTP Detoxification charts document that the client did not receive more than two detoxification treatment episodes in a 12-month period. QRI#145A.
- N/A - OTP Detoxification charts included documentation of client discharge when missing 3 consecutive days or more without notifying the program and providing a legitimate reason. QRI#146.
- N/A - OTP Detoxication charts had relevant client plans that included provisions to assist the patient to understand illicit drug addictions and how to deal with them. QRI#147.
- N/A - OTP Detoxification charts had relevant client plans that included provisions for furnishing services to the client as needed when the period of detoxification treatment was completed. QRI#148.

<u>Discharge from Treatment</u>

- 0% (0/1) of charts documented that the Discharge Plan was prepared (discussed and signed) within 30 calendar days prior to the date of the last face-to-face treatment with the client. QRI#149.
- 0% (0/1) of charts included a Discharge Plan with a description of each of the client's relapse triggers and a plan to assist the client to avoid relapse when confronted with triggers. QRI#150.
- 0% (0/1) of charts included a Discharge Plan which includes a support plan. QRI#151.
- 0% (0/1) of charts demonstrated that the LPHA or counselor provided a complete signature (typed or legibly printed name, credential, signature and date) on the Discharge Plan. QRI#152.
- 0% (0/1) of charts had a Discharge Plan with the client's name and signature on it. #153.
- 0% (0/1) of charts indicated that the client was provided a copy of Discharge Plan at last face-to-face service with client. QRI#154.
- N/A - charts did not claim for completing the Discharge Summary, except at OTPs when done prior to discharge. QRI#155.
- N/A - charts indicated that the Discharge Summary was completed within the required time frame. QRI#156.
- N/A - charts had a Discharge Summary that included the duration of treatment (admission date to last date of service). QRI#157.
- N/A - charts had a Discharge Summary that included a description of treatment episodes or recovery services (and best includes progress made towards plan goals). QRI#158.
- N/A - charts had a Discharge Summary that included the reason for discharge and whether the discharge was involuntary or a successful completion. QRI#159.
- N/A - charts had a Discharge Summary that included the client prognosis. QRI#160.

Chart / Agency Questions

- 83% (15/18) of charts had legible writing throughout. QRI#161.
- 71% (10/14) of charts included additional releases of information (ROIs), when applicable. QRI#162.
- 50% (9/18) of charts included the required ROI Tracker Log. Log was completed when client information was released. QRI#163.
- 50% (9/18) of charts included up-to-date emergency contact information and corresponding ROIs; or indicated as having no emergency contact. QRI#164.
- 56% (10/18) of charts provided emergency information in a designated location in file/EHR/InSyst. QRI#165.
- 11% (2/18) of charts contained evidence that treatment staff (LPHAs and SUD Counselors) who completed the ALOC assessment(s) had completed the three (3) required ASAM trainings. QRI#166.
- N/A - charts contained evidence that Peer Specialists who provided services during the audit period had completed the required Alameda County training program prior to providing Substance Abuse Monitoring Recovery Support Services (providers to submit evidence of peer training). QRI#167.
- 61% (11/18) of charts contained evidence all LPHAs relevant to this chart completed five (5) CEU hours of education in addiction treatment in the past year. QRI#168.
- 0% (0/1) of charts contained evidence that WM program staff who provided services during the audit period had been trained in the provisions of detoxification services. QRI#169.
- 83% (15/18) of charts contained no evidence that client was being charged any additional costs, except for share of cost, for treatment (this includes costs associated with drug testing/UA, administrative costs, certification fees, etc.). QRI#170.
- 83% (15/18) of charts included only ACBH designated acronyms and abbreviations. QRI#171
- N/A. QRIs 172 – 175 were skipped for this audit.
- 33% (6/18) of charts included the agency's Policy & Standards document. This document must cover services made during the audit period and was signed by the current Medical Director. QRI#176.
- N/A. QRI#177 skipped.
- 88% (7/8) of charts included the agency's valid AOD License/Certification for claims made during the audit period. AOD Certification/License is required for all residential programs and for all providers that have a current license or certification. QRI#178.

REGULATIONS; STANDARDS; POLICIES

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

- CA Code of Regulations, Title 9, Title 22

- DMC-ODS Intergovernmental Agreement
- Centers for Medicare & Medicaid Services Standards Terms & Conditions (CMS STCs)
- SAMHSA HIPAA; 42 CFR, Part 2
- DHCS MHSUDS Information Notices, ADP Bulletins
- CA Alcohol and/or Other Drug Program Certification Standards (AOD)
- Alameda County Behavioral Health Plan
    - ACBH SUD Practice Guidelines
    - ACBH CQRT Regulatory Compliance Tools for SUD
    - ACBH SUD Clinical Documentation Training

LIST OF EXHIBITS

- Exhibit 4: SUD Quality Review Item Key

RESOLUTION OF FINDINGS

Each provider has received an individualized Audit Findings Report detailing the findings for their chart(s), needed follow-up, and an individualized Corrective Action Plan (CAP) or Quality Improvement Plan (QIP) that lists all items to be addressed. Appeal information has been shared with providers through the individual Audit Findings Report.

Please note that chart audit results will be included in ACBH's required reporting to DHCS for CAP related items.

For questions or discussion related to this audit and its findings, please contact qa.appeals@acgov.org and indicate the Subject as: FY 18/19 SUD SOC Audit.

Sincerely,

Torfeh Rejali, LMFT

Torfeh Rejali, LMFT
Quality Assurance Administrator

CC: Karen Tribble, ACBH Director
Aaron Chapman, Behavioral Health Medical Director and Chief Medical Officer
Imo Momoh, MPA, Deputy Director/Plan Administrator
James Wagner, Deputy Director
Cecilia Serrano, Finance Director
Karen Capece, Quality Management Program Director
Clyde Lewis Jr., Interim Substance Use Disorder Continuum of Care Director
Wendi Vargas, Assistant Contracts Director
Lisa Moore, Billing and Benefits Director
Jill Louie, Budget and Fiscal Services Director
Andrea Judkins, Revenue Manager
Mandy Chau, Audit and Cost Reporting Director