alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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- MEMORANDUM -

DATE: May 31, 2022

TO: Alameda County Behavioral Health (ACBH) Specialty Mental Health (SMHS) Providers

FROM: Torfeh Rejali, Quality Assurance (QA) Administrator Torfeh Rejali

SUBJECT: Medi-Cal SMHS Reasons for Recoupment, Fiscal Year 2021/2022, Non Hospital Services

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This memorandum announces a change to the DHCS reasons for recoupment for SMHS non hospital services for fiscal year 2021/2022. This information was released by the State as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

Background

CalAIM is a California initiative led by the Department of Health Care Services (DHCS) that aims to provide broad delivery system, program, and payment reform across the Medi-Cal system. The goal of the initiative is to transform the Medi-Cal delivery system, moving it towards a population health approach that prioritizes prevention and whole person care. The vision is to "meet people where they are in life, address social drivers of health and break down the walls of health care."

Medi-Cal SMHS Reasons for Recoupment, Fiscal Year 2021/2022

With the release of the BHIN 21-053 on December 30, 2021, DHCS released the Medi-Cal SMHS Reasons for Recoupment for Fiscal Year 2021/2022, Non Hospital Services.

DHCS has not waived the requirement for Counties to complete provider audits during the pandemic and/or while CalAIM changes are being implemented. The new published Reasons for Recoupment will be used by ACBH for chart audits in FY 2021/2022.

Below is a summary of the reasons for recoupment for non Short-Doyle, non hospital, Medi-Cal services. Please refer to the document for more details and specific information related to Short-Doyle Medi-Cal Hospital Services.

Medical Necessity / Beneficiary Criteria / Need for Specialty Mental Health Services / Assessment

1. Mental Health Plan (MHP) did not submit documentation that Medical Necessity Criteria was met and that substantiated the beneficiary's need for Specialty Mental Health Services (SMHS).

Clinical Documentation

2. The MHP claimed for a service where the MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:
    a. There was no Progress Note or other clinical documentation to substantiate the service was provided.
    b. The Progress Note or other clinical documentation indicated "No show" or "Appointment cancelled" but a service (other than chart review) was still claimed.
    c. The documented service provided did not meet the applicable definition of a SMHS.
3. The service provided was not within the scope of practice of the person delivering the service.
4. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

5. The service claimed did not match the service documented in the progress note. ("Recovery" is limited to mismatches resulting in "overbillings").
6. The date of service documented in the progress note does not match the date of service claimed. ("Recovery" is limited to examples where the MHP is unable to provide other documented evidence that the progress note with the "mismatched" date actually corresponds to the claim in question, and/or was due to a clerical error).
7. The units of time claimed for the service are higher than the amount of time of the service documented in the progress note. ("Recovery" is limited to mismatches resulting in "overbillings").
8. For service activities involving one (1) or more providers, progress notes, or other relevant documentation in the medical record, did not clearly include the following:
    a. The total number of providers and their specific involvement in the context of the mental health needs of the beneficiary;
    b. The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable;
    c. The total number of beneficiaries participating in the service activity.
9. The claim for a group activity, which is provided as a Mental Health Service, Medication Support, Crisis Intervention, or TCM service, was not properly apportioned to all clients present, and resulted in excess time claimed. ("Recovery" is limited to apportionments resulting in "overbillings").
10. The service provided was a Non-Reimbursable Service and was solely for one of the following:
    a. Academic educational service
    b. Vocational service that has work or work training as its actual purpose.
    c. Recreation
    d. Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.
    e. Transportation
    f. Clerical
    g. Payee Related
11. The beneficiary received the service at a location that was ineligible for Federal Financial Participation (e.g., Institution for Mental Disease [IMD], jail, and other similar settings, or in setting subject to lockouts).
    NOTE: When a beneficiary who resides in a setting in which s/he would normally be ineligible for Medi-Cal is moved off grounds to an acute psychiatric inpatient hospital or PHF, that individual again becomes Medi-Cal eligible (unless the hospital is free-standing with more than 16 beds and is thus considered an IMD and the beneficiary is between the ages of 21-64).
12. The service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (A dependent minor in a juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary, is Medi-Cal eligible. A delinquent minor is only Medi-Cal eligible after adjudication for release into community.)

Day Treatment Intensive / Day Rehabilitation (DTI/DR)

13. On a day where the beneficiary was present for at least 50% of the scheduled DTI/DR program time, but was not in attendance for the full hours of operation for that day, there is no documentation of the reason for an "unavoidable absence" which clearly explains why the beneficiary could not be present for the full program on the day claimed.

14. The actual number of hours and minutes the beneficiary attended the DTI/DR program (e.g., 3 hours and 58 minutes) is not documented and for this reason it cannot be established that the beneficiary was present for at least 50% of the program time for the day reviewed.
15. Documentation reviewed, including the written weekly schedule for DTI/DR along with the progress notes, reflects that the program does not meet the time requirements for a half-day or full-day program as follows:
    a. Half day program was less than 3 hours (requirement is for 4 hours or less, but a minimum of 3 hours)
    b. Full day program was 4 hours or less (requirements is for more than 4 hours)
16. Required DTI/DR documentation was not present as follows:
    a. There was not a clinical summary present for Day Treatment Intensive Services for the week of the service reviewed.
    b. There was not a daily progress note present for Day Treatment Intensive Services for the day of the service reviewed.
    c. There was not a weekly progress note present for Day Rehabilitation Services for the week of the service reviewed.

Action Required

Please share this information with your teams as appropriate.

ACBH will continue to review new information during monthly Brown Bag meetings. We welcome questions and opportunities for clarification of the many significant changes. Brown Bags are scheduled every other Friday from 12pm-1pm. **The next Brown Bag meeting is planned for Friday June 3, 2022 from 12:00-1:00 pm.**

If you do not have the meeting already on your calendar, below is the link and call-in information:

Link: https://global.gotomeeting.com/join/173324541

United States (Toll Free): 1 877 309 2073; United States: +1 (646) 749-3129
Access Code: 173-324-541

For questions, please contact QATA@acgov.org.