ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES (ACBHCS)

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

Audit Performed in 4nd Quarter of 2017
For Audit Period: 1/1/2017 – 3/31/2017

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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 feedback in regard to documentation strengths as well as training needs for ACBHCS programs and services across the system of care. Because the selection of claims for the review employed a random sampling method, it may be utilized to generalize findings to 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 1/1/2017 -3/31/2017 from Emanio (database which pulls information from the InSyst Medi-Cal claiming program) for adult and child Medi-Cal beneficiaries. Twenty Eight (28) charts, twenty (20) unique clients, from twenty (20) providers and a total of four hundred sixty five (465) claims were reviewed for compliance and quality of care utilizing a standardized chart audit protocol.

See Exhibit 1 to see the claims that were reviewed by client chart and by provider. Exhibit 2 lists the DHCS Reasons for Recoupment with ACBHCS Claims Comments for fiscal year 2016-2017. Each chart was reviewed for compliance with Medi-Cal claiming requirements and for ACBHCS 2016-2017 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 Spreadsheet (Exhibit 1), the DHCS Reasons for Recoupment with ACBHCS Claims Comments for fiscal year 2016 – 2017 (Exhibit 2) while reviewing this section. Overall, of the 465 total claims examined by QA staff, 392 claims (84%) met the documentation standards and 73 claims (16%) were disallowed because they did not meet the standards.

The claims compliance of 84% is similar compared to the Q2 2017 Audit that had a compliance rate of 85%.

In the next section we describe in detail the claims compliance findings by providers' age group served, by dollar amount, by chart, by provider, by reason for recoupment of paid claims, and by service modality. Table #1 below specifies claims compliance by providers' age group served. Providers serving adults had significantly higher claims disallowances than those serving TAY and children.

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Table #1: Claims Compliance by Providers				
Providers	**Number of Claims**	**Allowed Claims**	**Disallowed Claims**	**Percent Compliant**
All	465	392	73	84%
Child Providers	340	301	39	86%
Adult & Older Adult Providers	125	91	34	73%

The total number of claims reviewed was four hundred sixty five (465) with a total service cost of $103,851.48. The total number of allowed claims was three hundred ninety-two (392) with a total service cost of $89,281.48. The total number of disallowed claims was seventy-three (73) with a total service cost of $14,570.00. Please see Table #2 (Claims Compliance by Dollar Amount) below**.**

See Table #2: Claims Compliance by Dollar Amount		
Claims	**Amount**	**Dollars**
Total	465	$103,851.48
Allowed	392	$89,281.48
Disallowed	73	$14,570.00

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 $21,340.08.
The breakdown across all providers, for the *number of charts falling into claims compliance ranges* is listed below. 32% of the charts (9 of 28) scored in the compliance range of 95-100% 32% of the charts (9 of 28) scored in the compliance range of 85% - 94%, 11% of the charts (3 of 28) scored in the compliance range of 75 – 84%, and 0% of the charts (0 of 28) scored in the compliance range of 65% - 74%, 25% of the charts (7 of 28) scored below 65% compliance.

See Table #3 (Claims Compliance Results by Chart) below:

Table #3: Claims Compliance Results by Chart		
Number of Charts	**Charts % Compliance**	**Percentage of Total**
9	95% – 100%	32%
9	85% – 94%	32%
3	75% – 84%	11%
0	65% – 74%	0%
7	< 65%	25%

The *average claims compliance per provider* indicated that 25% of providers (5 of 20) scored below 65% compliance, 30% of the providers (6 of 20) scored in the compliance range of 95% - 100%, 35% of providers (7 of 20) scored in the compliance range of 85%-94%, 5% of the

providers (1 of 20) scored in the compliance range of 75% - 84%, and 5% (1 of 20) scored in the compliance range of 65% - 74%.

Table #4: Claims Compliance Results by Provider		
Number of Providers	**Average Chart Compliance %**	**Percentage of Total**
6	95%-100%	30%
7	85%-94%	35%
1	75%-84%	5%
1	65%-74%	5%
5	< 65%	25%

The ACBHCS reasons for claims disallowances in this audit are listed below. Please refer to Exhibit #2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for FY 2017-2018 for categories of claims disallowances. See Table #5 (Reasons for Recoupment of PAID Claims by Frequency) below:

	Table #5: Reasons for Recoupment of PAID Claims by Frequency			
DHCS Reasons for Recoupment	**Reason for Recoupment**	**Type of Service**	**Frequency**	**% of Reasons for Disallowance**
1a, 2, 3, 4	Before 30 days the Assessment not past due and Planned Services have been provided where full Medical Necessity has not been established in each Planned Services Progress Note (by Licensed LPHA or Waivered/Registered LPHA with Licensed LPHA co-signature)	Assessment	0	0%
1b, 2, 3, 4	Assessment past due	Assessment	0	0%
1c, 2, 3, 4	Assessment not signed by Licensed/Waivered/Registered LPHA, or Trainee with Licensed LPHA co-signature	Assessment	0	0%
1d, 2, 3, 4	Non-Included Diagnosis.	Assessment	0	0%
1e, 2, 3, 4	Documentation in the Assessment does not support	Assessment	0	0%

	the included diagnosis. (DSM Diagnostic Criteria is not met, or adequately documented, for a M/C Included Diagnosis.)			
1f, 2, 3, 4	Diagnosis is not established by licensed LPHA OR not co-signed by licensed LPHA if established by a waivered staff or registered intern.	Assessment	0	0%
5a	A planned SMHS is provided before the Initial Client Plan due date, and medical and service necessity for the planned service is not documented in the completed mental health assessment. Note: Per DHCS Info Notice 17-040 no planned services can ever be provided before completion of a treatment plan. This take effect in ACBHCS on 3/1/2018.	Client Plan	7	7%
5b 6b	No Initial or Annual Client Plan.	Client Plan	0	0%
5c 6c	Initial or Annual Client Plan is late and planned services were provided during period of time where there is not an active treatment plan.	Client Plan	0	0%
5d 6d	Initial or Annual Client Plan is missing required staff signature(s) for date of service.	Client Plan	0	0%
5e 6e	There is not a current (not expired) mental health objective in the Initial or Annual Client Plan.	Client Plan	0	0%
5f 6f	Service modality claimed is not indicated in Initial or annual Client Plan.	Client Plan	19	20%
6g	Plan is not updated (re-written) when clinical need	Client Plan	0	0%

	arises.			
7a	No client (or guardian) signature on Client Plan for date of service, w/o documentation of reason	Client Plan	4	4%
7b	Late client (or guardian) signature on Client Plan for date of service, w/o documentation of reason.	Client Plan	0	0%
8a	Documentation of TBS Class Certification is not in the chart and is not provided upon request. TBS Class Certification requires M/C beneficiaries be under the age of 21 and meet one of the following criteria: Is placed in RCL 12 or above and/or another locked treatment facility for the treatment of mental health needs; Is being considered for placement in a locked treatment facility; Is at risk of psychiatric hospitalization; Has been psychiatrically hospitalized in the past 24 months; Previously received TBS while a member of the certified class.	TBS	0	0%
8b	No TBS Plan (or not within Client Plan).	TBS	0	0%
8c	The TBS Plan (or Client Plan) does not document: 1) Specific target behaviors or symptoms that are jeopardizing the current place of residence or presenting a barrier to transitions (e.g. temper	TBS	0	0%

	tantrums, property destruction, and assaultive behavior in school). 2) Specific interventions to resolve behaviors or symptoms, such as anger management techniques. 3) Specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and has been replaced by adaptive behaviors. 4) A transition plan from the inception of TBS to decrease or discontinue TBS when these services are no longer needed or when the need to continue TBS appears to have reached a plateau in benefit effectiveness. 5) The manner for assisting parents/caregivers with skills and strategies to provide continuity of care when the service is discontinued (if the TBS client is 18 – 20 yrs, the transition plan will only involve the parents/caregivers/other significant support persons with appropriate consent from the client).			
9	No Progress Note was found for service claimed	Progress Notes	3	3%

10a	Documentation content does not support amount of time claimed	Progress Notes	12	13%
10b	Time documented on Progress Note does not equal time claimed (overbilled)	Progress Notes	1	1%
10c	Written documentation does not support documentation time claimed or documentation time is excessive (Documentation time > 25% of total time).	Progress Notes	8	8%
10d	Time on Progress Note is not broken down into face-to-face and total time (for time based codes—crisis, ind. psychotherapy, E/M when > 50% of face-to-face time is spent as Counseling & Coordination of Care).	Progress Notes	0	0%
11	The Progress Note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation.	Progress Notes	0	0%
12	The Progress Note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).	Progress Notes	0	0%

13a	The Progress Note indicates that the service provided was Academic educational service	Progress Notes	1	1%
13b	The Progress Note indicates that the service provided was for vocational service that has work or work training as its actual purpose	Progress Notes	0	0%
13c	The Progress Note indicates that the service provided was recreational related	Progress Notes	0	0%
13d	The Progress Note indicates that the service provided was social group related	Progress Notes	0	0%
14a	Group service note does not include # of clients served	Progress Notes	0	0%
14b	Group service note does not include # of staff present	Progress Notes	0	0%
14c	Group Time claimed is inaccurately calculated	Progress Notes	0	0%
15a	Progress note is missing service provider signature.	Progress Notes	0	0%

15b	Progress note is missing required LPHA co-signature.	Progress Notes	0	0%
16	Non-billable activity: transportation related	Progress Notes	0	0%
17a	Non- billable electronic-type activity – voicemail/email/text/IM, etc.	Progress Notes	0	0%
17b	Non- billable activity – scheduling appointment related.	Progress Notes	1	1%
17c	Non- billable activity – Other clerical/administrative related.	Progress Notes	0	0%
18	The progress note indicates the service provided was solely payee related.	Progress Notes	0	0%
19a1	SMHS claimed does not match type of SMHS documented	Progress Notes	21	22%
19a2	Progress Note does not include required components: a) service being addressed the day of M/C claim is associated with an existing (current – not expired) MH Objective in the Client Plan, b) Staff's	Progress Notes	4	4%

	Mental Health Intervention for the date of service, c) Client's response to that day's Staff Intervention.			
19a3	Progress Note includes extensive cut & paste activity for: Staff's Intervention, OR Client's Response to Staff Intervention.	Progress Notes	0	0%
19a4	Case closed, cannot bill.	Progress Notes	0	0%
19a5	Client deceased, cannot bill.	Progress Notes	0	0%
19a6	Non SMHS Service Intervention: a) service is a Non-MH one, b) the completed Brief Screening Tool (Mild-Moderate vs. Moderate-Severe) for a client 18 years and older indicated that they should have been referred to a Mild-Moderate Provider.	Progress Notes	4	4%
19a7	Illegible Progress Note	Progress Notes	0	0%
19a8	Duplication of Services: a) same service billed twice by same provider, b) same service by different providers without documentation to support	Progress Notes	1	1%

	co-staffing.			
19a9	Non billable activity - Time claimed includes supervision related activities.	Progress Notes	1	1%
19a10	Day Rehabilitation / Day Treatment Intensive did not include all the required service components.	Progress Notes	0	0%
19a11	The total number of minutes/hours the client actually attended Day Rehabilitation / Day Treatment Intensive were not documented.	Progress Notes	0	0%
19a12	The client did not receive the minimum required hours in order to claim for full or half Day Rehabilitation / Day Treatment Intensive services.	Progress Notes	0	0%
19a13	Day Rehabilitation / Day Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).	Progress Notes	0	0%
19a14	Non-billable activity – housing support related (solely or in part without time apportioned).	Progress Notes	0	0%
19a15	Non-billable activity – No show	Progress Notes	0	0%

19a16	Non-billable activity – Non-therapeutic mandated reporting – written and/or telephone (CPS/APS) (solely or in part without time apportioned).	Progress Notes	0	0%
19a17	Writing reports for non-clinical treatment purposes (SSI, CFS, etc.) (Solely or in part without time apportioned).	Progress Notes	0	0%
19a18	Non-billable activity – Interpretation related (solely or in part). If staff is interpreting, no other services may be claimed by that person.	Progress Notes	0	0%
19a19	Review of medical records without clinical justification and documentation of relevant content found.	Progress Notes	0	0%
19a20a	Area of C/M need is not indicated in Assessment, Client Plan, or Progress Note(s) as required.	Progress Notes	8	8%
19a20b	Medical need for C/M is not supported in Assessment, Client Plan, or Progress Note(s) as required: Record indicates for clients ≥18 years – symptoms/impairments of Included Diagnosis prevent client from utilizing community supports in C/M area of need OR for clients <18 years, area of need (housing, medical, educational, SUD, etc.) exacerbates client's	Progress Notes	0	0%

	symptoms/impairments of Included Diagnosis.			
19a20c	Service need for C/M is not supported in Assessment, Client Plan, or Progress Note(s) as required: Record indicates successful result of C/M services (now housed, receiving medical care, etc.) will decrease client's symptoms/impairments of Included Diagnosis).	Progress Notes	0	0%
19b	Service was claimed for a provider on the Office of Inspector General List of Excluded Individuals and Entities.		0	0%
19c	Service was claimed for a provider on the Medi-Cal suspended and ineligible provider list.		0	0%
19d	Service was not provided within the scope of practice of the person delivering the service.		0	0%
20a	For beneficiaries receiving TBS, the TBS Progress Notes overall clearly indicate that TBS was provided for convenience of the family, caregivers, physician, or teacher.	TBS	0	0%
20b	For beneficiaries receiving TBS, the TBS Progress Notes overall clearly indicate that TBS was provided for purpose of client/youth supervision or to ensure compliance with	TBS	0	0%

	terms and conditions of probation.			
20c	For beneficiaries receiving TBS, the TBS Progress Notes overall clearly indicate that TBS was provided for purpose of ensuring the child's/youth's physical safety or the safety of others, e.g., suicide watch.	TBS	0	0%
20d	For beneficiaries receiving TBS, the TBS Progress Notes overall clearly indicate that TBS was provided to address conditions that are not part of the child's/youth's mental health condition	TBS	0	0%
21	For beneficiaries receiving TBS, the Progress Note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.	TBS	0	0%
Totals			95	*98%

*based on rounding off percentage numbers

The reasons for claims disallowances may be grouped into categories.

Thirty-one percent (31%) of the reasons for disallowance were related to the Client Plan requirements for the following reasons:
A Planned Service is provided before the Initial Client Plan due date, and medical and service necessity for the Planned Service is not documented in the completed Mental Health Assessment; Service Modality claimed is not indicated in the Initial or Annual Client Plan; no client (or guardian) signature on the Client Plan for date of service, without documentation of reason why.

Sixty-seven percent (67%) of the reasons for disallowance were related to Progress Notes requirements for the following reasons:

No Progress Note was found for service claimed; documentation content does not support amount of time claimed; time documented on Progress Note does not equal time claimed (overbilled); documentation does not support documentation time claimed or documentation time is excessive (documentation time > 25% of total time); Progress Note indicates that the service provided was an academic or educational service; non- billable activity – scheduling appointment related; SMHS claimed does not match type of SMHS documented; Progress Note does not include required components: a) service being addressed the day of M/C claim is associated with an existing (current – not expired) MH Objective in the Client Plan, b) staff's mental health intervention for the date of service, c) client's response to that day's staff intervention; non SMHS Service Intervention: a) service is a non-MH one, b) the completed Brief Screening Tool (Mild-Moderate vs. Moderate-Severe) for a client 18 years and older indicated that they should have been referred to a Mild-Moderate Provider; duplication of Services: a) same service billed twice by same provider, b) same service by different providers without documentation to support; non billable activity - time claimed includes supervision related activities; area of Case Management need is not indicated in Assessment, Client Plan, or Progress Note(s) as required.

Table #6 below categorizes the reasons for claims disallowances as described above:

Table #6 Reasons for Claims Disallowances	
Reasons Category	Percent of Disallowance Reasons
Client Plan	31%
Progress Notes	67%

The percentages of disallowed claims for each service modality are listed below in descending frequency. See Table #7 (Percentage of Modality Types Disallowed) below:

Table #7: Percentage of Modality types Disallowed.			
Disallowed MH Services by Modality	**Number of Claims Disallowed**	**Total Number of Claims (by type) across all charts audited.**	**Percentage of Claims Disallowances by Modality Type**
Collateral	10	46	22%
Medication Management/E&M	2	24	8%
Case Management /Brokerage	9	24	38%
Individual Rehabilitation	24	140	17%
TBS	0	23	0%
Plan Development	7	33	21%
Individual Psychotherapy	8	66	12%
Evaluation/Assessment	12	75	16%
Family Therapy	0	19	0%
Group Therapy	0	12	0%
Group Rehabilitation	1	3	33%

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 188 Quality Review Items (QRIs), were analyzed in this audit. They included: *Informing Materials, (Mild-Moderate-Severe) Screening, Medical Necessity, Assessments, Client Plans, TBS, Special Needs, Medication Log Issues, Progress Notes, and Chart Maintenance. Note that Day Rehabilitation, Psychiatric Emergency services, and site certification compliance was not reviewed for this audit.*

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 (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 # 69 "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.

The overall compliance rate for the Quality Review was 87% (see Exhibit 3). The results of the Quality Review for twenty-eight (28) charts demonstrated that 54% of the charts scored in the 85% - 94%, 18% of the charts scored in the 75% - 84% range, 18% of the charts scored in the 95% - 100% range, 11% of the charts scored in the 65% - 74% range, and 0% of the charts scored below 65%. See table #8: (Quality Review Compliance by Chart) below:

Table #8: Quality Review Compliance by Chart		
Number of Charts	**Quality Compliance Rate**	**Percentage**
5	95% – 100%	18%
15	85% – 94%	54%
5	75% – 84%	18%
3	65% – 74%	11%
0	<65%	0%

- ACBHCS Screening:
  - 36% (8/22) of the charts had the most recent required ACBHCS Screening Tool completed with required signatures, 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 # 11)
  - 67% (14/21) 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 #12)

- ACBHCS Informing Materials:
  - 68% (19/28) 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 #13)

- Medical and Service Necessity (*These are crucial items that if not met result in claims disallowances)*:
  - 79% (22/28) 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)
  - 79% (22/28) 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)

- 79% (22/28) 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)
- 79% (22/28) 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>

- 100% (26/26) 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 100%. (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 50%. (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 51%. (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.*
- 92% (24/26) 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)
- 88% (23/26) 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)
- 92% (24/26) 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)

- 94% (15/16) of the charts included pre/perinatal events and relevant/significant developmental history for youth in the most recent required assessment. (QRI #25)
- 100% (26/26) 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)
- 85% (22/26) of the charts documented allergies/adverse reactions/sensitivities, or lack thereof, in the record. (QRI #27)
- 81% (21/26) 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 62%. (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 58%.
  (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 46%. (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.*
- The compliance rate for completion of the CFE/CANS/ANSA/ANSA-T being completed on time for the audit period was 67%. (QRI #32)
- 73% 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).*

➢ <u>Client Plans</u>:

- 82% of client plans for the audit period were completed and signed on time by all required staff. (QRI #34)
- 94% 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 #35)
    - *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).

- 71% of the Mental Health Objectives listed in the most recent required Client Plans, across all charts, were observable or measureable with timeframes and preferably baselines. (QRI #36)
- 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 #37)
  - *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.*
- 36% 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 #38)
  - *All modalities should list the frequency and timeframes (i.e. Psychotherapy 1x/week, **AND** as needed, for 12 months).*
- 64% 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 #39)
  - *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…"*
- 78% (7/9) 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 #40)
- 71% (5/7) 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 #41)
  - *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** a specific Safety Plan. Progress Notes must also document the ongoing assessment and interventions of these risks.*
- 95% (18/19) of the charts showed evidence of coordination of care when it was applicable. (QRI #42)
- 100% (7/7) 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 #43)
  - *This is a crucial item that results in disallowances for all claimed services after the Client Plan should have been updated.*

- 77% (10/13) of the most recent required Client Plans for the audit period, across all charts, were signed/dated by MD/NP if applicable. (QRI #44)
- 66% 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 #45)
    - *This is a crucial item that if not met, results in claims disallowances for planned services (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.*
- 95% (21/22) 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 #46)
    - *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.*
- 73% (16/22) 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 #47)
    - *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). <u>If the Client Plan in the record is not in English, an English translation of the Client Plan **must also** be in the client's chart.</u>*
- 77% (17/22) 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.*

➢ <u>Therapeutic Behavioral Services (TBS):</u> *There were no TBS charts reviewed for this audit*.

- 100% (2/2) of TBS client records indicate that the client/youth met one of the following criteria (QRI #49):
    - *Client currently placed in a RCL 12 or above group home and/or locked treatment facility*
    - *Client is being considered by county for a RCL 12 or above group home and/or locked treatment facility*
    - *Client has had at least one psychiatric hospitalization in the preceding 24 months related to current presenting disability*
    - *Client received TBS while a member of the certified class*
    - *Client is at risk of requiring psychiatric hospitalization.*

- 100% of the Progress Notes clearly indicate that TBS was NOT provided for one of the following reasons: (QRI #50)
  - *For the convenience of the family, caregivers, physician, or teacher*
  - *To provide supervision or to ensure compliance with terms and conditions or probation*
  - *To ensure the child's/youth's physical safety or the safety or others, e.g. suicide*
  - *To address conditions that are not part of the child's/youth's mental health condition.*
- 100% of TBS claims during the audit were not provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility. (QRI #51)
- 100% (2/2) of TBS plans or Client Plans document specific target behaviors or symptoms that are jeopardizing the current place of residence or presenting a barrier to transitions. (QRI #52)
- 100% (2/2) of TBS plans or Client Plans document detailed interventions to resolve behaviors or symptoms, such as anger management techniques. (QRI #53)
- 100% (2/2) of TBS plans or Client Plans document specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and has been replaced by adaptive behaviors. (QRI #54)
- 100% (2/2) of TBS plans or Client Plans document a transition plan from the inception of TBS to decrease or discontinue TBS when these services are no longer needed or when the need to continue TBS appears to have reached a plateau in benefit effectiveness. (QRI #55)
- 100% (2/2) of TBS plans or Client Plans document the manner for assisting parents/caregivers with skills and strategies to provide continuity of care when the service is discontinued. (QRI #56)

➢ <u>Special Needs:</u>

- 93% (26/28) 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 #57)
- Of those with noted cultural and communication needs, 85% (17/20) of those charts addressed them as appropriate. (QRI #58)
- 77% (20/26) of the most recent required Client Plans or Assessments for the audit period noted client's physical limitations, or lack thereof. (QRI #59)
- Of those with noted physical limitations, 33% (3/9) of those charts addressed the physical limitations as appropriate. (QRI #60)

➢ <u>Medication Log Issues:</u>

- 100% (14/14) 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 #61)
- 100% (14/14) 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 #62)

- 100% (14/14) 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 #63)
- 100% (14/14) 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 #64)
- 100% (14/14) 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 #65)
- 87% of the required Informed Consent for Medication(s) and JUV 220/3 (required for foster children) were completed and signed when applicable. (QRI #66)
    - *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 57% (QRI #67)
    - *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).*
- N/A of the E/M Progress Notes audited for E/M standards were compliant. (QRI #68)
    - *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 reflects the results across all charts.*)

- There was a Progress Note for 100% of all service contacts. (QRI #69)
- 86% of the Progress Notes had the correct CPT Code/exact procedure name, and/or INSYST service code for the mental health services provided. (QRI #70)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 99% 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 #71)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 92% of the Progress Notes indicated the correct location of service. (QRI #72)

- 77% of the Progress Notes documented both face-to-face time and total time. (QRI #73)
    - *For service codes that are time based--this is a crucial item that if not met, results in claims disallowances.*
- 99% of the Progress Notes documented time that equaled the time that was claimed. (QRI #74)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 92% of the Progress Notes had reasonable time noted for documentation. (QRI #75)
    - *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 #76)
    - *This is a crucial item that if not met, may result in claims disallowances.*
- 100% 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 #77)
- 98% of the Progress Notes included a description of a staff specialty mental health service (SMHS) **I**ntervention for that day's service. *(QRI #78)
    - *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 #79)
- 71% 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 #80)
    - **The "P/BIRP" Progress Note Format is not required, but the associated elements are.*
- 95% of planned services were provided after the completion of client's treatment plan. (For this audit, a completed mental health assessment that included medical and service necessity for the planned service was considered in compliance. Per ACBHCS memo dated 2/23/18 no planned services can be provided before the completion of a client's treatment plan (effective 3/1/2018). (QRI #81)
- 97% of the group service Progress Notes included correct calculation of the time and listed the number of clients served. (QRI #82)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the Progress Notes documented services that related back to the mental health objectives listed in the Client Plan. (QRI #83)
    - *This is a crucial item that if not met, may result in claims disallowances.*
- 92% (12/13) of the charts contained documentation that addressed unresolved issues from prior services, when applicable. (QRI #84)
- 100% of the Progress Notes were signed. (QRI #85)
- 100% of the Progress Notes signatures included the date. (QRI #86)
- 91% of the Progress Notes signatures included the staff Medi-Cal designation (may also list credential on Provider Signature Page/Sheet in chart). (QRI #87)

  - *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).*
- 99% of the Progress Notes had a completion line after the signature if applicable (N/A if EHR). (QRI #88)
- 100% 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 #89)
  - *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 #90)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 100% 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 #91)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the claimed services provided were NOT transportation related. (QRI #92)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the claimed services provided were NOT clerical related. (QRI #93)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the claimed services provided were NOT payee related. (QRI #94)
  - *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 #95)
- 100% of the claimed services were provided when the client was NOT deceased. (QRI #96)
- 100% of the claimed services provided were NOT a non-billable activity for completion of the ACBHCS Screening Tool. (QRI #97)
- 100% of the claimed services provided were NOT a duplication of service. (QRI #98)
  - *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 #99)
- 95% 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 #100)
- 84% of the progress notes were completed and signed within the "late note" timeline required by the MHP) (QRI #101)
  - *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.*
- 40% of the progress notes that were late indicated "late note" in the body of the progress note. (QRI #102)
- 100% of the claimed services provided were NOT for housing support. (Case management services are allowed if it is justified that the intervention is for mental health symptoms and not housing support alone.) (QRI #103)
- 100% of the claimed services provided were NOT for a "No show" activity. (QRI#104)
- 100% of the claimed services provided were NOT for a non-therapeutic mandated reporting activity (mandated reported activities can be claimed if provided as a SMHS intervention with client or caregivers present.) (QRI#105)
- 100% of the claimed services provided were NOT for writing CPS/APS reports for non-clinical treatment purposes (mandated reported activities can be claimed if provided as a SMHS intervention with client or caregivers present.) (QRI#106)
- 100% of the claimed services provided were NOT for interpretation related activities. (QRI#107)
- 100% of the claimed services provided were NOT for a review of medical records without clinical justification and/or documentation of relevant content found. (QRI#108)
- 96% 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 #109)
- N/A of the progress notes indicated that interpreter services were used and the relationship to client was indicated, if applicable. (QRI #110)
- 98% of the progress notes documented that the service was provided within the scope of practice of the person delivering the service. (QRI #111)
- 89% of Case management/Brokerage types (housing, economic, vocational, educational, medical needs, SUD, etc.) were compliant. (QRI #112)

➢ <u>Chart Maintenance:</u>

- 93% (26/28) of the charts noted the admission date correctly (EOD noted in chart should match InSyst). (QRI #113)
- 18% (5/28) 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 #114)
- 85% of the required signed releases of information were present. (QRI #115)
- The compliance rate for legibility in the charts was 99%. (QRI #116)
  - *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.*
- 97% of the signatures on the documents throughout all charts were legible (or printed name under signature or signature sheet was present). (QRI #117)
  - *This is a crucial item that if not met, may result in claims disallowances.*

- 100% of the charts contained service-related client correspondence in the client's preferred language. (QRI#118)
- N/A% of the charts had treatment specific information provided to the client in an alternative format (e.g., braille, audio, large print, etc. (QRI#119)
- 100% (28/28) of the charts maintained a clinical record where documents were filed appropriately. (QRI #120)
- 86% of the pages across all charts identified the client (by name or InSyst #). (QRI #121)
- 100% (5/5) of the charts indicated the discharge/termination date correctly (matching InSyst), when applicable. (QRI #122)
- 98% of the documentation in the charts did not contain significant cut and paste activity. (QRI #123)
    - *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.*
- 93% (26/28) of the charts contained documentation which only used county-designated acronyms and abbreviations. (QRI #124)

- Day Rehabilitation Services
    - QRI Items #125 - 146 are all N/A because no charts providing Day Rehabilitative services were reviewed in this audit.

- Psychiatric Emergency Services / Crisis Stabilization Programs:
    - QRI Items #147 - 195 are all N/A because no charts providing Psychiatric Emergency or Crisis Stabilization services were reviewed in this audit.

- Site Compliance
    - QRI Items #196 - 198 are all N/A because this audit did not include site reviews.

RESOLUTION OF FINDINGS

All Twenty (20) providers that were audited have a unique section in the Addendum of this report that individualizes the findings of their reviewed chart(s). All data is thus confidential. Each provider has already received a Provider Audit Findings Letter detailing the findings for their chart(s) needed follow-up, and an individualized Plan of Correction or Quality Improvement Plan which lists all items to be addressed.

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 2016-2017
- 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

LIST OF EXHIBITS

Exhibit 1: Claim Review Spreadsheet
Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for FY 2016-2017
Exhibit 3: Quality Review Spreadsheet
Exhibit 4: Quality Review Key
Exhibit 5: POC/QIP Template

ADDENDUMS

Provider P12/Client C10 & C12

1. Quality Review Items Compliance:
   C10: 92%;
   C12: 90%

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

   b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 20, 21, 29, 30, 31, 37, 38, 70, 76, 78, 80, 87, 91, 112, 113, 114, 115.

2. Quality Improvement Plan Required: No

3. Claims Compliance: 88%

   a. Number of claims disallowed: 5

   b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 19a1, 10a, 13a, 6f, 19a2b.

4. Amount of claims (within the audit period) to be recouped: $933.12.

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P3/Client C3

2. Quality Review Items Compliance: 78%

    a. Number of Quality Items to be addressed in the Plan of Correction: 20

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 13, 20, 21, 22, 23, 28, 29, 30, 31, 32, 33, 59, 60, 73, 74, 75, 114, 123

3. Quality Improvement Plan Required: No

4. Claims Compliance: 90%

    a. Number of claims disallowed: 1

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

5. Amount of claims (within the audit period) to be recouped: $242.40.

6. Amount of claims (outside the audit period) to be recouped: $0.00

7. Plan of Correction Needed: Yes

Provider P4/Client C4

1. Quality Review Items Compliance: 92%

    a. Number of Quality Items to be addressed in the Plan of Correction: 10

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 29, 30, 32, 36, 37, 38, 39, 48, 70, 114

2. Quality Improvement Plan Required: No

3. Claims Compliance: 82%

    a. Number of claims disallowed: 2

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 19a1

4. Amount of claims (within the audit period) to be recouped: $533.28.

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P6/Client C5

1. Quality Review Items Compliance: 99%

    a. Number of Quality Items to be addressed in the Quality Improvement Plan: 4

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 73, 75, 101, 114

2. Quality Improvement Plan Required: Yes

3. Claims Compliance: 100%

    a. Number of claims disallowed: 0

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

4. Amount of claims (within the audit period) to be recouped: $0.00.

5. Amount of claims (outside the audit period) to be recouped: $0.00.

6. Plan of Correction Needed: No

Provider P10/ Client C8

1. Quality Review Items Compliance: 88%

    a. Number of Quality Items to be addressed in the Plan of Correction: 17

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 20, 21, 29, 30, 31, 33, 35, 38, 48, 59, 60, 72, 80, 81, 113, 114

2. Quality Improvement Plan Required: No

3. Claims Compliance: 100%

    a. Number of claims disallowed: 0

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: none within the audit period.

4. Amount of claims (within the audit period) to be recouped: $0.00.

5. Amount of claims (outside the audit period) to be recouped: $175.68.

6. Plan of Correction Needed: Yes

Provider P13/Client C11

1. Quality Review Items Compliance: 85%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 20, 21, 23, 24, 29, 30, 31, 35, 36, 40, 41, 58, 70, 76, 80, 99, 121

2. Quality Improvement Plan Required: No

3. Claims Compliance: 53%

    a. Number of claims disallowed: 7

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 10a, 19a9

4. Amount of claims (within the audit period) to be recouped: $1,607.52

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P14/ Client C12

1. Quality Review Items Compliance: 85%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 14, 15, 16, 17, 31, 37, 38, 42, 45, 46, 47, 75, 114, 121

2. Quality Improvement Plan Required: No

3. Claims Compliance: 88%

    a. Number of claims disallowed: 3

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

4. Amount of claims (within the audit period) to be recouped: $322.56

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P9/ Client C7

1. Quality Review Items Compliance: 70%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 13, 14, 15, 16, 17, 21, 22, 27, 28, 29, 30, 31, 32, 33, 38, 39, 45, 46, 47, 59, 60, 73, 76, 80, 101, 102, 114, 115, 121

2. Quality Improvement Plan Required: No

3. Claims Compliance: 100%

    a. Number of claims disallowed: 0

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

4. Amount of claims (within the audit period) to be recouped: $0.00.

5. Amount of claims (outside the audit period) to be recouped: $4,294.08.

6. Plan of Correction Needed: Yes

Provider P7-A, P7-B, P7-C, & P7-D/Client C6, C7, & C18

1. Quality Review Items Compliance:
   C6/P7-B: 86%
   C6/P7-D: 90%
   C7/P7-A: 88%
   C18/P7-B: 77%
   C18/P7-C: 83%

   a. Number of Quality Items to be addressed in the Plan of Correction: 46

   b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 13, 14, 15, 16, 17, 20, 21, 29, 30, 31, 32, 33, 34, 36, 37, 38, 39, 40, 44, 45, 47, 57, 58, 59, 60, 66, 67, 70, 73, 74, 76, 79, 80, 81, 82, 84, 87, 101, 102, 109, 111, 112, 114, 121

2. Quality Improvement Plan Required: No

3. Claims Compliance: 88%

   a. Number of claims disallowed: 16

   b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 5f, 19a1, 19a20a, 10a, 19a2c

4. Amount of claims (within the audit period) to be recouped: $1980.66

5. Amount of claims (outside the audit period) to be recouped: $4,138.22.

6. Plan of Correction Needed: Yes

Provider P20/Client C7

1. Quality Review Items Compliance: 74%

    a. Number of Quality Items to be addressed in the Plan of Correction: 26

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 14, 15, 16, 17, 20, 21, 23, 24, 27, 29, 30, 31, 32, 33, 35, 36, 38, 39, 46, 47, 70, 72, 73, 114, 115, 121

2. Quality Improvement Plan Required: No

3. Claims Compliance: 0%

    a. Number of claims disallowed: 1

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 19a1

4. Amount of claims (within the audit period) to be recouped: $682.76

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P11/Client C8 & C9

1. Quality Review Items Compliance:
   C8: 90%
   C9: 87%

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

   b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 20, 21, 25, 29, 30, 31, 45, 48, 70, 72, 73, 101, 102, 114

2. Quality Improvement Plan Required: No

3. Claims Compliance: 96%

   a. Number of claims disallowed: 1

   b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 19a1

4. Amount of claims (within the audit period) to be recouped: $224.64

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P5/ Client C5

1. Quality Review Items Compliance: 88%

    a. Number of Quality Items to be addressed in the Plan of Correction: 26

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 13, 21, 29, 32, 35, 37, 38, 39, 40, 41, 47, 48, 64, 66, 67, 73, 75, 80, 101, 102, 114, 121, 123, 124

2. Quality Improvement Plan Required: Yes

3. Claims Compliance: 100%

    a. Number of claims disallowed: 0

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

4. Amount of claims (within the audit period) to be recouped: $0.00

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: No

Provider P8/Client C7

1. Quality Review Items Compliance: 86%

    a. Number of Quality Items to be addressed in the Plan of Correction: 13

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 20, 21, 27, 28, 29, 30, 31, 33, 73, 76, 78, 100, 114

2. Quality Improvement Plan Required: No

3. Claims Compliance: 40%

    a. Number of claims disallowed: 3

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 19a6a, 10a

4. Amount of claims (within the audit period) to be recouped: $843.84

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P17/Client C15, C19, & C22

1. Quality Review Items Compliance:
   C15: 96%
   C19: 97%
   C22: 94%

   a. Number of Quality Items to be addressed in the Plan of Correction: 36

   b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 13, 20, 21, 29, 30, 31, 32, 37, 38, 39, 40, 41, 44, 45, 46, 67, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 82, 85, 86, 87, 88, 114, 116, 121

2. Quality Improvement Plan Required: No

3. Claims Compliance: 65%

   a. Number of claims disallowed: 14

   b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 5f, 9

4. Amount of claims (within the audit period) to be recouped: $2,347.20

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P20/Client C23

1. Quality Review Items Compliance: 82%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 14, 15, 16, 17, 31, 33, 34, 35, 36, 38, 39, 44, 45, 67, 73, 75, 80, 101, 102, 112, 114, 117, 123

2. Quality Improvement Plan Required: No

3. Claims Compliance: 90%

    a. Number of claims disallowed: 2

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

4. Amount of claims (within the audit period) to be recouped: $322.56

5. Amount of claims (outside the audit period) to be recouped: $2,640.96

6. Plan of Correction Needed: Yes

Provider P18/ Client C20

1. Quality Review Items Compliance: 90%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 13, 29, 31, 33, 34, 38, 46, 67, 76, 101, 102, 109, 114, 115

2. Quality Improvement Plan Required: No

3. Claims Compliance: 92%

    a. Number of claims disallowed: 1

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

4. Amount of claims (within the audit period) to be recouped: $657.66

5. Amount of claims (outside the audit period) to be recouped: $0.00

6. Plan of Correction Needed: Yes

Provider P15/ Client C13

7. Quality Review Items Compliance: 96%

    a. Number of Quality Items to be addressed in the Plan of Correction: 10

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 32, 40, 46, 70, 81, 98, 114, 117, 121

8. Quality Improvement Plan Required: No

9. Claims Compliance: 92%

    a. Number of claims disallowed: 1

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 19a1, 19a8b

10. Amount of claims (within the audit period) to be recouped: $115.20

11. Amount of claims (outside the audit period) to be recouped: $0.00

12. Plan of Correction Needed: Yes

Provider P19/ Client C21

13. Quality Review Items Compliance: 97%

    a. Number of Quality Items to be addressed in the Plan of Correction: 4

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 38, 41, 67, 70

14. Quality Improvement Plan Required: Yes

15. Claims Compliance: 100%

    a. Number of claims disallowed: 0

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

16. Amount of claims (within the audit period) to be recouped: $0.00

17. Amount of claims (outside the audit period) to be recouped: $0.00

18. Plan of Correction Needed: No

Provider P1/ Client C1

19. Quality Review Items Compliance: 67%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 13, 14, 15, 16, 17, 20, 21, 27, 28, 29, 30, 31, 32, 34, 37, 38, 39, 44, 45, 46, 47, 48, 59, 60, 66, 67, 80, 101, 102, 114

20. Quality Improvement Plan Required: no

21. Claims Compliance: 0%

    a. Number of claims disallowed: 4

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 6f, 7a

22. Amount of claims (within the audit period) to be recouped: $2,424.00

23. Amount of claims (outside the audit period) to be recouped: $9,392.50.

24. Plan of Correction Needed: Yes

Provider P2/ Client C2

25. Quality Review Items Compliance: 82%

    a. Number of Quality Items to be addressed in the Plan of Correction: 30

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 13, 14, 15, 16, 17, 20, 21, 27, 28, 29, 30, 31, 57, 58, 59, 60, 67, 70, 73, 74, 75, 78, 80, 81, 93, 100, 114, 117, 121, 124

26. Quality Improvement Plan Required: No

27. Claims Compliance: 29%

    a. Number of claims disallowed: 12

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBHCS Claims Comments for System of Care Audit Report): Item Numbers: 19a6a, 5a, 19a1, 10c, 19a2b, 17b, 19a20a

28. Amount of claims (within the audit period) to be recouped: $1,332.60

29. Amount of claims (outside the audit period) to be recouped: $0.00

30. Plan of Correction Needed: Yes