Mental Health System of Care Audit 2020

For Audit Period: 10/1/2019 – 12/31/2019

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INTRODUCTION:

This chart audit utilized a random sample review of Mental Health (MH) services for the Alameda County Behavioral Health (ACBH) 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 documentation standards for services claimed to Medi-Cal.

This report provides feedback in regard to documentation strengths as well as training needs for ACBH 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 ACBH Mental Health System of Care, and particularly for providers contracted by the county, for the audit period as a whole.

The Quality Assurance Office (QA) randomly sampled specialty mental health services (SMHS) claims data via the ACBH billing system (i.e. InSyst) for the time period of 10/1/2019 - 12/31/2019. Ten (10) charts from ten (10) providers and a total of one hundred and sixty-two (162) claims were reviewed for compliance and quality of care utilizing a standardized chart audit protocol.

ACBH utilized DHCS Reasons for Recoupment FY 2019-20. Each chart was reviewed for compliance with Medi-Cal claiming requirements and for ACBH 2018-2019 quality of care documentation standards. *(References: ACBH Clinical Documentation Standards Manual, 11/30/18 and the ACBH CQRT Regulatory Compliance Tool, 3/1/18.)*

CLAIMS REVIEW RESULTS:

Overall, of the one hundred sixty-two (162) total claims examined by QA clinical staff, one hundred and nineteen (119) claims (73%) met the documentation standards and forty-three (43) claims (27%) were disallowed because they did not meet the standards.

You may make a request to QATA@acgov.org if you would like to review the audit claims sheets.

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.

Table #1: Claims Compliance by Providers				
Providers	**Number of Claims**	**Allowed Claims**	**Disallowed Claims**	**Percent Compliant**
All	162	119	43	73%
Child Providers	67	55	12	82%
Adult & Older Adult Providers	95	64	31	67%

The total number of claims reviewed was one hundred sixty-two (162) with a total service cost of $52,122.15. The total number of allowed claims was one hundred and nineteen (119) with a total service cost of $40,383.58. The total number of disallowed claims was fifty-three (43) with a total service cost of $11,738.57. Please see Table #2 (Claims Compliance by Dollar Amount) below**.**

Table #2: Claims Compliance by Dollar Amount		
Claims	**Amount**	**Dollars**
Total	162	$52,122.15
Allowed	119	$40,383.58
Disallowed	43	$11,738.57

The *average claims compliance per provider* indicated that 20% of chart/providers (2 of 10) scored in the compliance range of 95% or higher, 10% of the providers (1 of 10) scored in the compliance range of 85% - 94%, 10% of providers (1 of 10) scored in the compliance range of 75%-84%, 30% of the providers (3 of 10) scored in the compliance range of 65% - 74%, and 30% (3 of 10) scored in the compliance range of less than 65%. See Table #3 (Claims Compliance Results by Provider) below:

Table #3: Claims Compliance Results by Chart/Provider		
Number of Providers	**Average Chart Compliance %**	**Percentage of Total**
2	95%-100%	20%
1	85%-94%	10%
1	75%-84%	10%
3	65%-74%	30%
3	< 65%	30%

The ACBH reasons for claims disallowances in this audit are listed below. Please refer to DHCS Reasons for Recoupment FY 2019-20 with ACBH Claims Comments for FY 2019-2020 categories of claims disallowances. See Table #4 (Reasons for Recoupment of PAID Claims by Frequency) below:

	Table #4: Reasons for Recoupment of PAID Claims by Frequency			
DHCS Reasons for Recoupment	**Reason for Recoupment**	**Type of Service**	**Frequency**	**% of Reasons for Disallowance**
2a	Documentation in the Assessment does not support the included diagnosis (DSM –V Diagnostic Criteria is not met or adequately documented for a M/C Included Diagnosis, the Assessment does not contain mental status exam; the Assessment only references an historical diagnosis).	Assessment	4	4%
2b	A planned SMHS service is provided before the completion of Initial Assessment.	Assessment	4	4%
2c	Assessment is late; there is a gap or lapse between Assessments and planned services have been claimed.	Assessment	4	4%
3a, 3b	a) Documentation in the Assessment does not support the impairment criteria for DSM V diagnosis. b) The condition can be treated in a physical health care-based setting only.	Assessment	4	4%
4a	A planned SMHS service is provided before the completion of the Initial Client Plan.	Client Plan	4	4%
4b	No Annual Client Plan for date of service; Annual Client Plan is late; there is a gap or lapse between Client Plans and planned services have been claimed.	Client Plan	1	1%
4e	Invalid Client Plan: No client (or guardian) signature on Client Plan, w/o documentation of reason.	Client Plan	10	10%
4g	The Client Plan is not updated when a clinical need arises.	Client Plan	4	4%
5b	Progress note does not contain a	Progress	4	4%

	mental health intervention.	Notes		
5c	Invalid intervention: there is extensive cut and paste activity for the intervention component of the progress note.	Progress Notes	5	5%
6b	Progress note does not contain a mental health intervention	Progress Notes	4	4%
6c	Invalid Intervention: there is extensive cut and paste activity for the intervention component of the progress note.	Progress Notes	5	5%
7a	Progress note does not contain a description of how services reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate the mental health (under 21).	Progress Notes	11	11%
7b	Progress note did not include client response.	Progress Notes	4	4%
7c	Invalid Response: there is extensive cut and paste activity for the client response component of the progress note.	Progress Notes	3	3%
8a	No progress note for the date of service.	Progress Notes	1	1%
8b	SMHS service claimed does not match the type of SMHS documented.	Progress Notes	10	10%
8e	Time documented on the progress note does not match time claimed.	Progress Notes	2	2%
8g	Documentation content does no support the amount of time claimed.	Progress Notes	3	3%
9	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	2	2%
11a	The progress note indicates that the service provided was Academic educational service (solely or in part without time apportioned).	Progress Notes	1	1%
11b	The progress note indicates that the service provided was for vocational service that has work or work	Progress Notes	2	2%

	training as its actual purpose (solely or in part without time apportioned).			
11f	The progress note indicates that the service was clerical related (solely or in part without time apportioned): 1. Voicemail/email/text/IM, etc. 2. Scheduling appointment 3. Other clerical/administrative	Progress Notes	1	1%
13d	Time on the progress note is not broken down into face-to-face and total time.	Progress Notes	7	7%
15b11	Review of medical records without clinical justification and documentation of relevant content found.	Progress Notes	3	3%
Totals			103	100%*

**based on rounding off of percentage numbers*

The reasons for claims disallowances may be grouped into categories. See Table 5 or details.

Table #5: Reasons for Claims Disallowances		
Category	**Percent of Disallowance Reasons**	**Reasons**
Mental Health Assessment	17%	• Documentation in the Assessment does not support the included diagnosis (DSM-5 Diagnostic Criteria is not met or adequately documented for a M/C Included Diagnosis, the Assessment does not contain mental status exam; the Assessment only references an historical diagnosis) • The Assessment is late • There is a gap or lapse between Assessments and planned services have been claimed • Documentation in the Assessment does not support the impairment criteria for DSM-5 diagnosis.

Client Plan	10%	• A planned SMHS service is provided before the completion of the Initial Client Plan • There is no Annual Client Plan for date of service • The Annual Client Plan is late • There is a gap or lapse between Client Plans and planned services have been claimed • The Client Plan is invalid due to no client (or guardian) signature on Client Plan, w/o documentation of reason • The Client Plan is not updated when a clinical need arises.
Progress Notes	73%	• Progress note does not contain a mental health intervention • Interventions are invalid due to extensive cut and paste activity for the intervention component of the progress note • Progress note does not contain a description of how services reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate the mental health (under 21) • Progress note did not include client response or included an invalid response due to extensive cut and paste activity for the client response component of the progress note • No progress note for the date of service • SMHS service claimed does not match the type of SMHS documented • Time documented on the progress note does not match time claimed • Documentation content does not support the amount of time claimed • 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 note indicates that the service provided was an academic educational service (solely or in part without time apportioned) • Progress note indicates that the service provided was for vocational service that has work or work training as its actual purpose (solely or in part without time apportioned) • Progress note indicates that the service was clerical related (solely or in part without time apportioned) • Time on the progress note is not broken down into face-to-face and total time • Review of medical records without clinical justification and documentation of relevant content found.

The percentages of disallowed claims for each service modality are listed in Table #6 (Percentage of Modality Types Disallowed) below:

Table #6: 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**
Family Therapy	2	3	67%
Evaluation/Assessment	2	26	8%
Medication Management/E&M	3	32	9%
Individual Psychotherapy	10	27	37%
Collateral	4	17	24%
Plan Development	7	13	54%
Case Management /Brokerage	9	32	28%
Individual Rehabilitation	6	11	55%
Crisis Therapy	0	1	0%

QUALITY REVIEW:

The Quality Review determined if the standards for documentation of Medi-Cal Specialty Mental Health Services had been met. Nine (9) Quality Review areas, with 125 Quality Review Items (QRIs), were analyzed in this audit. They included: Screening (Mild-Moderate-Severe), Informing Materials, Interim Assessments, Assessments, Client Plans, Special Needs, Medication Log and Consents, Progress Notes, and Chart Maintenance. Note that Day Rehabilitation, Psychiatric Emergency services, and site certification compliance were 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 Key (Exhibit 1) 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 1) for those that are also reasons for claims disallowance and recoupment.

As you read the report you will find percentages for each QRI which represent 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 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. For 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 # 75 "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 were 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.

Table #7 provides the overall Quality Review Compliance percentage. Of the 10 charts reviewed, 20% scored in the 95% - 100% compliance range and 80% in the 85% - 94% compliance range. The overall compliance rate for the Quality Review was 91%.

Table #7: Quality Review Compliance by Chart		
Number of Charts	**Quality Compliance Rate**	**Percentage**
2	95% – 100%	20%
8	85% – 94%	80%
0	75% – 84%	0%
0	65% – 74%	0%
0	<65%	0%

- ACBH Screening:
  - 80% (8/10) of the charts had the most recent ACBH 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)
  - 90% (9/10) of the charts showed evidence that the mental health condition met moderate to severe criteria based on the most recent required ACBH Screening Tool, when required per program. (QRI #12)

- ACBH Informing Materials:
  - 90% (9/10) of the charts had the most recent required ACBH Informing Material signature page completed and signed on time (within 30 days of EOD or annually by EOD) OR if late, documented reason in Progress Notes. (QRI #13)

- Interim Assessment:
  - QRIs #14 – #16. N/A. None of the charts reviewed in this audit contained an Interim Assessment.

- Assessments:
  - 100% (10/10) of the charts had a current primary DSM-5 diagnosis from the appropriate DHCS Medi-Cal Included list. (QRI#17)
  - 80% (8/10) of the charts had a current Assessment documenting medical necessity and the client's need for services for the full audit period. (QRI#18)
  - 80% (8/10) of the charts had an Assessment establishing the client's level of impairment and that, as result of the primary diagnosis, there was at least one of the following for the full audit period:
    - Significant impairment in important area of life functioning;
    - Probable significant deterioration in an important area of life functioning;
    - If child, probable the child wont progress developmentally, as appropriate;
    - If EPSDT, MH condition can be corrected or ameliorated. (QRI#19)
  - 100% (10/10) of the charts had presenting problems and relevant conditions included in the most recent required assessment. (QRI #20)
  - The compliance rate for assessing the four (4) required areas of psychosocial history in the most recent required assessments across all charts was 85% (QRI #21)
    - *Required components for psychosocial history: 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) in the most recent required assessments across all charts was 70%. (QRI#22)
  - *Required components: 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 73%. (QRI #23)
  - *Required components: 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.*
  - 80% (8/10) 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). (QRI #24)

- 90% (9/10) of the charts included the assessment of risks to client in the most recent required assessment. (For credit, Danger to Self should be assessed and if indicated, a description is required). (QRI #25)
- 90% (9/10) of the charts included the assessment of risks to others in the most recent required assessment. (For credit, Danger to Others should be assessed and if indicated, a description is required). (QRI #26)
- 100% (6/6) of the charts included pre/perinatal events and relevant/significant developmental history for youth in the most recent required assessment. (QRI #27)
- 100% (10/10) 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 #28)
- 100% (10/10) of the charts documented allergies/adverse reactions/sensitivities, or lack thereof, in the record. (QRI #29)
- 100% (10/10) of the charts noted allergies/adverse reactions/sensitivities, or lack thereof, on the chart cover, or if an EHR, in the field/location designated by the clinic. (QRI #30)
- 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 67%. (QRI #31)
    - *Required components: 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 78%. (QRI #32)
- *Required components: 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 74%. (QRI #33)
    - *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 100%. (QRI #34)
- The compliance rate for completion of the PSC-35 (and present in the client record, not just in Objective Arts, for relevant audit period was 60%. (QRI #35)
- 80% 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 #36)
    - *This item if not met, results in claims disallowances (until met).*

➢ Client Plans:

- 90% of client plans for the audit period were completed and signed on time by all required staff. (QRI #37)

- 99% 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 #38)
    - *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 item if not met, results in claims disallowances (until met).*
- 80% of the Mental Health Objectives listed in the most recent required Client Plans, across all charts, were observable or measurable with timeframes and preferably baselines. (QRI #39)
- 100% 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 #40)
    - *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.*
- 90% 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 #41)
    - *All modalities should list the frequency and timeframes (i.e. Psychotherapy 1x/week,* ***and*** *as needed, for 12 months).*
- 98% 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 #42)
    - *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…"*
- 50% (3/6) of the charts had a plan for containment for risk(s) (within the last 90 days of indication of risk or potential risk) <u>to client (DTS)</u> if applicable. (QRI #43)
- 50% (2/4) of the charts had a plan for containment for risk(s) (within the last 90 days of indication of risk or potential risk) <u>to others (DTO)</u> if applicable. (QRI #44)
    - *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.*
- 89% (8/9) of the charts showed evidence of coordination of care when it was applicable. (QRI #45)
- 60% (3/5) 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 #46)
    - *This is a crucial item that results in disallowances for all claimed services after the Client Plan should have been updated.*

- 100% (6/6) of the most recent required Client Plans for the audit period, across all charts, were signed/dated by MD/NP if applicable. (QRI #47)
- 90% 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 #48)
    - *This item 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.*
- 90% (9/10) 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 #49)
    - *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.*
- 80% (8/10) 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 #50)
    - *If the client speaks a threshold language, in order to receive credit for this item, the plan or related progress note should contain 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 **should also** be in the client's chart.</u>*
- 90% (9/10) 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 #51)
    - *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>Special Needs:</u>

- 90% (9/10) 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 #52)
- Of those with noted cultural and communication needs, 67% (4/6) of those charts addressed them as appropriate. (QRI #53)
- 100% (10/10) of the most recent required Client Plans or Assessments for the audit period noted client's physical limitations, or lack thereof. (QRI #54)
- Of those with noted physical limitations, 100% (1/1) of those charts addressed the physical limitations as appropriate. (QRI #55)

➢ <u>Medication Log Issues:</u>

- 100% (7/7) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) that was updated at each visit with date of prescription, when applicable. (QRI #56)
- 100% (7/7) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) that was updated at each visit with the drug name, when applicable. (QRI #57)
- 86% (6/7) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) that was updated at each visit with the drug strength/size, when applicable. (QRI #58)
- 100% (7/7) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) that was updated at each visit with the instruction/frequency for administration of the medication, when applicable. (QRI #59)
- 100% (7/7) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) that was updated at each visit with the prescriber's signature or initials, when applicable. (QRI #60)
- 87% of the required Informed Consent for Medication(s) and JUV 220/3 (required for foster children) were completed and signed when applicable. (QRI #61)
    - *This is a significant item that should 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 86% (QRI #62)
    - *Consents for Medication should 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 for the E/M Progress Notes. (QRI #63)
    - *Note, this is for informational purposes only. The medication services were audited to the DHCS Medi-Cal standard only.*

➢ <u>Progress Notes</u> (*Each of the percentages reflects the results across all charts.*)

- 95% of the Progress Notes demonstrate that the focus of the 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;
--If EPSDT: MH condition can be corrected or ameliorated. (QRI #64)

- *This item 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

- 95% of the Progress Notes demonstrate the expectation that the proposed intervention will do, at least, one of the following:
  --Significantly diminish the impairment;
  --Prevent significant deterioration in an important area of life functioning;
  --Allow the child to progress developmentally as individually appropriate; or
  --For EPSDT, correct or ameliorate the condition. (QRI #65)
  - *This item 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
- 93% % of the Progress Notes describe how services provided to the client reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a client's (under the age of 21) mental health condition. (QRI#66)
  - *This item if not met, results in claims disallowances. All progress notes must contain a Response component to demonstrate how this criteria is met.*
- There was a Progress Note for 99% of all service contacts. (QRI #67)
- 92% of the Progress Notes had the correct CPT Code/exact procedure name, and/or INSYST service code for the mental health services provided. (QRI #68)
  - *This item 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 #69)
  - *This item if not met, results in claims disallowances.*
- 91% of the Progress Notes indicated the correct location of service. (QRI #70)
- 86% of the Progress Notes documented both face-to-face time and total time. (QRI #71)
  - *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 the total number of providers and their specific involvement in providing the service. (QRI #72)
- 99% of the Progress Notes documented the total number of clients participating in the service activity. (QRI #73)
- 98% of the Progress Notes documented time that equaled the time that was claimed. (QRI #74)
  - *This item if not met, results in claims disallowances.*
- 95% of the Progress Notes had reasonable time noted for documentation. (QRI #75)
  - *This item if not met, may result in claims disallowances.*
- 97% of the Progress Notes had documented content that supported the amount of direct service time claimed. (QRI #76)

    - *This item if not met, may result in claims disallowances.*
- 99% 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)
- 99% of the Progress Notes were legible. (QRI #78)
- 95% 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)
    - *This item if not met, results in claims disallowances. All progress notes must contain a Response component to demonstrate how services provided to the client reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a client's (under the age of 21) mental health condition.*
- 91% 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.*
- 96% of planned services were provided after the completion of client's Assessment or with a current (not expired) Assessment. (QRI #81)
    - *This item if not met, results in claims disallowances.*
- 96% of planned services were provided after the completion of the Client Plan or with a current (not expired) Client Plan. (QRI #82)
    - *This item if not met, results in claims disallowances.*
- N/A there were no group services audited for this audit. Group service Progress Notes included correct calculation of the time and listed the number of clients served. (QRI #83)
    - *This item if not met, results in claims disallowances.*
- 99% of the Progress Notes documented services that related back to the mental health objectives listed in the Client Plan. (QRI #84)
    - *This item if not met, may result in claims disallowances.*
- 50% (2/4) of the charts contained documentation that addressed unresolved issues from prior services, when applicable. (QRI #85)
- 99% of the Progress Notes were signed. (QRI #86)
- 90% of the Progress Notes signatures included the date. (QRI #87)
- 99% of the Progress Notes signatures included the staff Medi-Cal designation (may also list credential on Provider Signature Page/Sheet in chart). (QRI #88)
    - *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 document that the service provided was within the scope of practice of the person delivering the service. (QRI #89)
    - *This item if not met, may result in claims disallowances.*

- 67% of the Progress Notes required to have the completion line after the signature were compliant. (QRI #90).
- 98% 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 #91)
  - *This item if not met, results in claims disallowances.*
- 99% of the claimed services were NOT provided while the client was in juvenile hall (unless documentation of an adjudication order is obtained) (QRI #92)
  - *This item if not met, results in claims disallowances.*
- 96% 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 #93)
  - *This item if not met, results in claims disallowances.*
- 99% of the claimed services provided were NOT transportation related. (QRI #94)
  - *This item if not met, results in claims disallowances.*
- 99% of the claimed services provided were NOT clerical related. (QRI #95)
  - *This item if not met, results in claims disallowances.*
- 99% of the claimed services provided were NOT payee related. (QRI #96)
  - *This item if not met, results in claims disallowances.*
- 100% of the claimed services were provided when the case was open to the provider. (QRI #97)
- 100% of the claimed services were provided when the client was NOT deceased. (QRI #98)
- 99% of the claimed services provided were NOT a non-billable activity for completion of the ACBH Screening Tool (if the Screening Tool is integrated into the Assessment, the time can be claimed). (QRI #99)
- 99% of the claimed services provided were NOT a duplication of service. (QRI #100)
  - *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.*
- 99% of the claimed services provided were NOT supervision related. (QRI #101)
- 96% 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 #102)
- 61% of the progress notes were completed and signed within the “late note” timeline required by the MHP) (QRI #103)
  - *The current ACBH 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.*
- 48% of the progress notes that were late indicated “late note” in the body of the progress note. (QRI #104)

- 99% 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 #105)
- 99% of the claimed services provided were NOT for a "No show" activity. (QRI#106)
- 99% 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#107)
- 99% 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#108)
- 99% of the claimed services provided were NOT for interpretation related activities. (QRI#109)
- 97% of the claimed services provided were NOT for a review of medical records without clinical justification and/or documentation of relevant content found. (QRI#110)
- 99% 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 #111)
- 96% of the progress notes indicated that interpreter services were used and the relationship to client was indicated, if applicable. (QRI #112)
- 88% of Case management/Brokerage types (housing, economic, vocational, educational, medical needs, SUD, etc.) were compliant. (QRI #113)

➢ Chart Maintenance:

- 90% (9/10) of the charts noted the admission date correctly (EOD noted in chart should match InSyst). (QRI #114)
- 60% (6/10) 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 #115)
- 71% of the required signed releases of information were present. (QRI #116)
- The compliance rate for legibility in the charts was 98%. (QRI #117)
    - *This item 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.*
- 96% of the signatures on the documents throughout all charts were legible (or printed name under signature or signature sheet was present). (QRI #118)
    - *This item if not met, may result in claims disallowances.*
- 100% of the charts contained service-related client correspondence in the client's preferred language. (QRI#119)
- 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#120)
- 86% (6/7) of the charts maintained a clinical record where documents were filed appropriately. (QRI #121)

- 100% of pages across all charts identified the client (by name or InSyst #). (QRI #122)
- N/A of the charts indicated the discharge/termination date correctly (matching InSyst), when applicable. (QRI #123)
- 94% of the documentation in the charts did not contain significant cut and paste activity. (QRI #124)
    - *This item 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.*
- 70% (7/10) of the charts contained documentation that only used county-designated acronyms and abbreviations. (QRI #125)

➢ Day Rehabilitation Services

- QRIs #126 - #146 are all N/A because no charts providing Day Rehabilitative services were reviewed in this audit.

RESOLUTION OF FINDINGS

All of the 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 in the addendums are de-identified in order to maintain client/provider confidentiality. Each provider has also 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.

If you have questions regarding this report, please contact ACBH QA at qa.appeals@acgov.org.

Thank you for your partnership,

Torfeh Rejali, LMFT

Torfeh Rejali, LMFT
Quality Assurance Administrator

cc: Imo Momoh, MPA, Deputy Director/Plan Administrator
Ravi Mehta, Chief Compliance & Privacy Officer
James Wagner, Deputy Director
Cecilia Serrano, Finance Director
Karen Capece, Quality Management Program Director
Lisa Carlisle, Director, Child & Young Adult System of Care
Kate Jones, Director, Adult & Older Adult System of Care
Edilyn Velasquez, Contracts Director
Wendi Vargas, Assistant Contracts Director
Lisa Moore, Billing & Benefits Director
Jill Louie, Budget & Fiscal Services Director
Andrea Judkins, Revenue Manager

Mandy Chau, Audit & Cost Reporting Director

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 2019-2020
- Centers for Medicare & Medicaid Services
- Alameda County Behavioral Health Plan
    - Alameda County Behavioral Health Care Services Clinical Documentation Standards Manual (v.11/30/2018)
    - ACBH CQRT Regulatory Compliance Tools

LIST OF EXHIBITS

Exhibit 1: Quality Review Key

ADDENDUMS

Provider P1 / Client C1

1. Quality Review Items Compliance: C1: 97%

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

    b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Quality Improvement Plan: 22, 23, 31, 70.

2. Quality Improvement Plan needed: Yes

3. Claims Compliance: 100%
    a. Number of claims disallowed: 0

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

4. Amount of claims (within the audit period) to be recouped: N/A

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

6. Corrective Action Plan required: No

Provider P2 / Client C2

1. Quality Review Items Compliance: C2: 90%

    a. Number of Quality Items to be addressed in the Corrective Action Plan: 57
    b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 13, 25, 26, 31, 32, 35, 38, 43, 44, 45, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 84, 86, 87, 88, 89, 91, 92, 93, 94, 95, 96, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 116, 118, 125.

2. Quality Improvement Plan Required: No

3. Claims Compliance: 75%

    a. Number of claims disallowed: 3

    b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
    Item Numbers: 2b, 4a, 8a, 8b.

4. Amount of claims (within the audit period) to be recouped: $1,182.50

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

6. Corrective Action Plan needed: Yes

Provider P3 / Client C3

1. Quality Review Items Compliance: C4: 88%
   a. Number of Quality Items to be addressed in the Corrective Action Plan: 19

   b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 11, 18, 22, 31, 32, 33, 38, 39, 42, 43, 46, 52, 53, 61, 64, 71, 103, 104, 115.

2. Quality Improvement Plan Required: No

3. Claims Compliance: 59%

   a. Number of claims disallowed: 7

   b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
   Item Numbers: 13d

4. Amount of claims (within the audit period) to be recouped: $2,294.05

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

6. Corrective Action Plan needed: Yes

Provider P4 / Client C4

1. Quality Review Items Compliance: C4: 91%

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

    b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 17, 18, 22, 23, 31, 35, 43, 46, 53, 68, 71, 76, 79, 93, 103, 104, 115

2. Quality Improvement Plan Required: No

3. Claims Compliance: 88%

    a. Number of claims disallowed: 2

    b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
    Item Numbers: 8b, 11a

4. Amount of claims (within the audit period) to be recouped: $709.50

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

6. Corrective Action Plan needed: Yes

Provider P5 / Client C5

1. Quality Review Items Compliance: C5: 93%

    a. Number of Quality Items to be addressed in the Corrective Action Plan: 11

    b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 18, 19, 33, 37, 39, 48, 49, 50, 70, 85, 103

2. Quality Improvement Plan Required: No

3. Claims Compliance: 100%

    a. Number of claims disallowed: 0

    b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
    Item Numbers: NA

4. Amount of claims (within the audit period) to be recouped: $0

5. Amount of claims (planned services) outside the audit period to be recouped: $0

6. Total recoupment amount: $0

7. Corrective Action Plan needed: No

Provider P6 / Client C6

1. Quality Review Items Compliance: C6: 96%

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

    b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 37, 40, 64, 65, 66, 91, 95, 103, 104, 113, 114, 116, 124

2. Quality Improvement Plan Required: No

3. Claims Compliance: 74%%

    a. Number of claims disallowed: 6

    b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
    Item Numbers: 5b, 5c, 6b, 6c, 7a, 9, 11f1

4. Amount of claims (within the audit period) to be recouped: $755.32

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

6. Corrective Action Plan needed: Yes

Provider P7 / Client C7

1. Quality Review Items Compliance: C7: 86%

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

    b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 18, 21, 22, 23, 24, 25, 26, 31, 33, 41, 42, 44, 46, 49, 50, 51, 58, 62, 64, 65, 66, 68, 70, 76, 77, 79, 80, 85, 94, 103, 104, 113, 115, 116, 124, 125

2. Quality Improvement Plan Required: No

3. Claims Compliance: 67%

    a. Number of claims disallowed: 10

    b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
    Item Numbers: 4g, 8b, 8g, 7a, 5b, 6b

4. Amount of claims (within the audit period) to be recouped: $1,754.40

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

6. Corrective Action Plan needed: Yes

Provider P8 / Client C8

1. Quality Review Items Compliance: C8: 90%

    a. Number of Quality Items to be addressed in the Corrective Action Plan: 22

    b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 11, 18, 19, 21, 24, 33, 36, 37, 66, 68, 71, 76, 79, 81, 82, 84, 93, 103, 104, 113, 116, 124

2. Quality Improvement Plan Required: No

3. Claims Compliance: 62%

    a. Number of claims disallowed: 5

    b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
    Item Numbers: 11b, 8g, 8b, 7b, 7a, 2c, 3a, 4b, 2a

4. Amount of claims (within the audit period) to be recouped: $1,684.05

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

6. Corrective Action Plan needed: Yes

Provider P9 / Client C9

1. Quality Review Items Compliance: C9: 85%

   a. Number of Quality Items to be addressed in the Corrective Action Plan: 34

   b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 11, 18, 19, 21, 22, 24, 25, 31, 32, 33, 36, 37, 39, 41, 43, 61, 62, 64, 65, 66, 70, 71, 74, 75, 79, 80, 87, 90, 103, 104, 111, 115, 116, 124

2. Quality Improvement Plan Required: No

3. Claims Compliance: 73%

   a. Number of claims disallowed: 4

   b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
      Item Numbers: 5c, 6c, 7c, 7b, 8e

4. Amount of claims (within the audit period) to be recouped: $946.44

5. Amount of claims (planned services) outside the audit period to be recouped: $211.80

6. Total recoupment amount: $1,158.24

7. Corrective Action Plan needed: Yes

<u>Provider P10 / Client C10</u>

1. Quality Review Items Compliance: C10: 90%

    a. Number of Quality Items to be addressed in the Corrective Action Plan: 28

    b. The Quality non-compliance reasons (Exhibit 1: Quality Review Key) to be addressed in the Corrective Action Plan: Quality Review Items: 17, 18, 19, 20, 22, 23, 24, 25, 26, 32, 36, 43, 44, 62, 68, 75, 77, 81, 82, 91, 93, 103, 104, 110, 117, 118, 121, 125

2. Quality Improvement Plan Required: No

3. Claims Compliance: 57%

    a. Number of claims disallowed: 6

    b. Reasons for DHCS claims disallowances (DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report):
    Item Numbers: 2a, 2b, 3a, 2c, 4a, 8b, 15b11

4. Amount of claims (within the audit period) to be recouped: $2,412.30

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

6. Corrective Action Plan needed: Yes

Exhibit 1: Quality Review Key SOC 2020 Audit

The following Key/Questions is an abbreviated version of Alameda County Behavioral Health (ACBH) Quality Assurance audit tool. Chart Auditors and staff use this tool when reviewing medical records. The questions assess for compliance with State and County charting/documentation requirements as well as the quality of care that beneficiaries are receiving. Some of the questions are associated with claims recoupment, but a significant portion are not and result in quality feedback only.

These questions provide directions to auditors on how to score and assess items for compliance. Many State and County requirements can be vague or difficult to apply in complex situations. These directions help Auditors remain consistent in identifying deficiencies, scoring the deficiency, and giving feedback about the deficiency during the audit period.

Readers of this report can use this Key to understand the methods used by Alameda County Auditors to assess for quality of care, score, and give feedback when deficiencies are determined.

CHART AND PROVIDER REVIEW:

The following questions are used to keep track of which staff are present at agencies audited and which staff completed certain documents at the agency. This information is used in future questions in the audit. Questions 1-10 are identifying questions only and do not have compliance scores associated with them.

1. CLIENT IDENTIFICATION (Client Mask ID#)
2. AGENCY IDENTIFICATION (Provider Mask RU#)
3. EPISODE OPEING DATE (EOD)
4. ASSESSMENT STAFF 1
5. ASSESSMENT STAFF 2
6. CT PLAN STAFF 1
7. CT PLAN STAFF 2
8. PN STAFF 1
9. PN STAFF 2
10. MD/NP/PA

Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

Scoring Key:

[1] ***Yes=100% No=0%:*** *These quality review items have either a 'Yes' or 'No' answer*

[2] ***True=100% False=0%:*** *These quality review items have either a 'True' or 'False' answer*

[3] ***# present/total required:*** *These quality review items can score from a range of 0-100%*

[4] ***# of items or areas compliant/# items or areas evaluated****: These quality review items can score from a range of 0-100%*

[5] ***% of those audited that are compliant:*** *These quality review items can score from a range of 0-100%*

SCREENING:

The following questions are used to assess compliance with screening beneficiaries to determine if they meet criteria to receive Specialty Mental Health Services or if they should be referred to their primary care provider for services.

11. The most recent required ACBH Screening Tool for the audit period has been completed - correct version for age (0-5, 6-17, or 18+) with proper signatures?[1] (The Screening Tool should be completed before opening the case or during the Assessment process and before every Annual Assessment due date). The Screening Tool must be completed by a Licensed, registered, or waivered LPHA, or second year graduate trainee/student (with appropriate training and experience and attestation by licensed supervisor). If completed by a registered or waivered LPHA or second year graduate trainee/student, it must be co-signed by a licensed LPHA. [1]
12. For all required Brief Screening Tools, the mental health condition meets the criteria for Moderate to Severe?[1]

INFORMING MATERIALS:

The following questions are used to assess compliance with the requirement to provide and review informing materials with beneficiaries.

13. The most recent required ACBHCS Informing Materials signature page is completed in client's/representative's primary or preferred threshold language and completed within required time frame? (Initial form is due by assessment due date. It is required to be signed/dated by beneficiary (or legal representative) and initialed/dated by clinician/staff. Informing materials are required to be reviewed annually by date of admission as indicated by beneficiary/legal representative's initials & date. If late, reason is documented in progress notes.) [1]

INTERIM ASSESSMENT:

The following questions are used for a special circumstance that requires an "Interim Assessment" be completed prior to providing "Planned services." Most services and medical records do not require "Interim Assessments."

Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

Scoring Key:

[1] ***Yes=100% No=0%:*** *These quality review items have either a 'Yes' or 'No' answer*

[2] ***True=100% False=0%:*** *These quality review items have either a 'True' or 'False' answer*

[3] ***# present/total required:*** *These quality review items can score from a range of 0-100%*

[4] ***# of items or areas compliant/# items or areas evaluated****: These quality review items can score from a range of 0-100%*

[5] ***% of those audited that are compliant:*** *These quality review items can score from a range of 0-100%*

14. There is a current primary DSM-5 diagnosis from appropriate DHCS Medi-Cal Included list?[1] A historical diagnosis (including a recent inpatient DX) may not be simply references as the current Dx without re-diagnosis. [DHCS reason for recoupment #1: *MHP Contract, Exhibit A, Attachment 3; Title 9 of the California Code of Regulations (CCR)1830.205(b)(1) and 1830.210; and, Mental Health and Substance Use Disorder Services Information Notices]*
15. The Interim Assessment establishes medical necessity and the client's need for services?[1] [DHCS reason for recoupment #2: *MHP Contract, Exhibit A, Attachment 2*]
16. The Interim Assessment establishes the client's level of impairment 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;
    - If child, probable the child won't progress developmentally, as appropriate;
    - If EPSDT: MH condition can be corrected or ameliorated.[1] [DHCS reason for recoupment #3: *CCR, Title 9, chapter 11, Section 1830.205(b)(2)(A – C); CCR, Title 9, chapter 11, Section 1830.210(a)(3)*]

ASSESSMENT:

The following questions are used to assess compliance with various required components of Specialty Mental Health Assessments.

17. There is a current primary DSM-5 diagnosis from the appropriate DHCS Medi-Cal Included list?[1] [DHCS reason for recoupment #1: *MHP Contract, Exhibit A, Attachment 3; Title 9 of the California Code of Regulations (CCR)1830.205(b)(1) and 1830.210; and, Mental Health and Substance Use Disorder Services Information Notices]*
18. For the full audit period, there is a current Assessment which documents medical necessity and the client's need for services?[1] [1] [DHCS reason for recoupment #2: *MHP Contract, Exhibit A, Attachment 2*]
19. For the full audit period, there is a current Assessment which establishes the client's level of impairment 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;

Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

Scoring Key:

[1] ***Yes=100% No=0%:*** *These quality review items have either a 'Yes' or 'No' answer*

[2] ***True=100% False=0%:*** *These quality review items have either a 'True' or 'False' answer*

[3] ***# present/total required:*** *These quality review items can score from a range of 0-100%*

[4] ***# of items or areas compliant/# items or areas evaluated****: These quality review items can score from a range of 0-100%*

[5] ***% of those audited that are compliant:*** *These quality review items can score from a range of 0-100%*

- If child, probable the child won't progress developmentally, as appropriate;
- If EPSDT: MH condition can be corrected or ameliorated.[1] [DHCS reason for recoupment #3: *CCR, Title 9, chapter 11, Section 1830.205(b)(2)(A – C); CCR, Title 9, chapter 11, Section 1830.210(a)(3)*]

20. The most recent required Assessment includes presenting problems and relevant conditions?[1]
21. The most recent required Assessment includes psychosocial history including:[4] 1) living situation, 2) daily activities, 3) social support, and 4) history of trauma or exposure to trauma?
22. The most recent required Assessment contains information about current and past psychiatric medications (or lack thereof) the client has received, including duration of medical treatment?[4] Scoring categories: 1) current psychiatric meds, 2) duration of treatment with current psychiatric meds, 3) past psychiatric meds, 4) duration of treatment with past psychiatric meds.
23. The most recent required Assessment contains information about current and past medications to treat medical conditions (or lack thereof) the client has received, including duration of medical treatment?[4] Scoring categories: 1) current meds, 2) duration of treatment with current meds, 3) past meds, 4) duration of treatment with past meds.
24. The most recent required Assessment includes a mental status exam (MSE)?[1] All noted abnormal findings or impairments must be described to receive credit for this item. [DHCS reason for recoupment #2: *MHP Contract, Exhibit A, Attachment 3; Title 9 of the California Code of Regulations (CCR)1830.205(b)(1) and 1830.210; and, Mental Health and Substance Use Disorder Services Information Notices]*
25. For the most recent required Assessment, Risk(s) to client assessed?[1] Danger to self must be assessed and noted, whether or not present, and if present, a description is required. Any additional risk areas should be assessed and noted if present. Any serious risk that has been identified within the last 90 days MUST include a comprehensive risk assessment and a separate formal written safety plan as well as being addressed in the client plan.
26. For the most recent required Assessment, Risk(s) to others assessed?[1] Danger to others must be assessed and noted, whether or not present, and if present, a description is required. Any additional risk areas should be assessed and noted if present. Any serious risk that has been identified the last 90 days MUST include a

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Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

Scoring Key:

[1] ***Yes=100% No=0%:*** *These quality review items have either a 'Yes' or 'No' answer*

[2] ***True=100% False=0%:*** *These quality review items have either a 'True' or 'False' answer*

[3] ***# present/total required:*** *These quality review items can score from a range of 0-100%*

[4] ***# of items or areas compliant/# items or areas evaluated****: These quality review items can score from a range of 0-100%*

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comprehensive risk assessment and a separate formal written safety plan as well as being addressed in the client plan.

27. The most recent required Assessment includes pre/perinatal events and relevant/significant developmental history for youth?[1]
28. Documentation of the client/family strengths in achieving client plan goals or objectives are
    included in most recent required Assessment or most recent required Client Plan?[1]
29. Allergies/adverse reactions/sensitivities OR lack thereof are noted in the record?[1]
30. Allergies/adverse reactions/sensitivities OR lack thereof are noted prominently on the chart cover, or if an EHR, it is in the field/location designated by the clinic?[1]
31. For the most recent required Assessment, relevant medical conditions/hx noted including the name of current source of medical treatment (or lack thereof)?[4] Scoring categories: 1) medical conditions, 2) name of current provider, 3) address of current provider
32. For the most recent required Assessment, mental health history noted including:[4] 1) previous treatment (including inpatient admissions), 2) previous providers, 3) therapeutic modalities, and 4) response
33. For the most recent required Assessment, past and present substance exposure/substance use of tobacco, alcohol, caffeine, CAM, OTC drugs, illicit drugs, and use (other than as prescribed) of Rx drugs assessed & noted?[3]
34. Required CANS/ANSA/ANSA-T completed (and in the client record, not just in Objective Arts) for relevant audit period?[1]
35. Required PSC-35 completed (and present in the client record, not just in Objective Arts) for relevant audit period?
36. Assessment(s) (initial and annual) required during the audit period are completed and signed by all required participants on time?[1] [DHCS reason for recoupment #2: *MHP Contract, Exhibit A, Attachment 2*]

CLIENT PLAN:

The following questions are used to assess compliance with various required components of Specialty Mental Health Client Plans.

37. Are all Client Plans for the audit period completed and signed on time by all required staff (other than MD)? Note: Non-LPHA (Adjunct, Trainee, and MHRS staff) require

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Licensed LPHA co-signature. [DHCS reason for recoupment #4: *MHP Contract.; State Plan, Section 3 to Att. 3.1-A (SPA 12-025, page 2c; MHSUDS Information Notice 17-040*]

38. The objectives listed in all Client Plans for the audit period are current (not expired per written effective dates for the dates of service related to them) Mental Health Objectives and directly address the symptoms/impairments of the included diagnosis?[5] [DHCS reason for recoupment #4: *MHP Contract.; State Plan, Section 3 to Att. 3.1-A (SPA 12-025, page 2c; MHSUDS Information Notice 17-040*]
39. The Mental Health Objectives listed in the most recent required Client Plan are observable/measurable with time frames?[5]
40. All Client Plans for the audit period list proposed Service Modalities?[3] [DHCS reason for recoupment #4: *MHP Contract.; State Plan, Section 3 to Att. 3.1-A (SPA 12-025, page 2c; MHSUDS Information Notice 17-040*]
41. For the most recent required Client Plan, the frequency and time frames are listed for each Service Modality?[5]
42. The most recent required Client Plan describes detailed provider interventions for each service modality listed in the Plan?
43. For the complete audit period, Risk(s) (within last 90 days of assessment of risk) to client (DTS) have plan for containment if applicable?[1]
44. For the complete audit period, Risk(s) (within last 90 days of assessment of risk) to others (DTO) have a plan for containment if applicable?[1]
45. For the complete audit period, Coordination of care is evident, when applicable?[1]
46. For the complete audit period, the Client Plan is updated when there are significant changes in service, diagnosis, focus of treatment, etc.?[1] [DHCS reason for recoupment #4: *MHP Contract.; State Plan, Section 3 to Att. 3.1-A (SPA 12-025, page 2c; MHSUDS Information Notice 17-040*]
47. Is the most recent required Client Plan signed/dated by MD/NP if applicable?[1]
48. Are all Client Plans for the audit period signed/dated by client or legal representative when appropriate or documentation of client refusal or unavailability?[5] [DHCS reason for recoupment #4: *MHP Contract.; State Plan, Section 3 to Att. 3.1-A (SPA 12-025, page 2c; MHSUDS Information Notice 17-040*]
49. Does the most recent required Client Plan (or related progress note) include documentation of the client's participation in and agreement with the Client Plan?[1]
50. Does the most recent required Client Plan indicate that the client/representative (signatory) was offered a copy of the plan? [1]

Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

Scoring Key:

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51. Does the most recent required Client Plan contain a Tentative Discharge Plan (anticipated timeframe, readiness indicators and/or possible referrals at d/c)?[1]

SPECIAL NEEDS:

The following questions are used to determine is a beneficiary was assessed for special needs.

52. The Client's cultural and communication needs, or lack thereof, have been noted in the most recent required client plan/assessment?[1]
53. If identified, were cultural and communication needs addressed as appropriate?[1]
54. The Client's physical limitations, or lack thereof, are noted in most recent required client plan/assessment?[1]
55. If identified, were physical limitations addressed as appropriate?[1]

MEDICATION LOG, MEDICATION CONSENTS, & E/M SERVICES:

The following questions are used to assess compliance with various required components of Medication Logs, Medication Consents, and E/M Services.

56. Med log (or note) updated at each visit with date of Rx?[1]
57. Med log (or note) updated at each visit with drug name?
58. Med log (or note) updated at each visit with strength/size?
59. Med log (or note updated at each visit with instruction/frequency of Rx?
60. Med log (or note which requires signature) updated at each visit with prescriber's signature/initials?
61. Informed Consent for Medications(s) and JU 220/3 (req's for foster children) when applicable?
62. The informed consent form for medications explains each:[4] (1) Rx name, (2) specific dosage or range, (3) administration route, (4) expected uses/effects (reasons used), (5) short term and LT (beyond 3 mos.) 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 client was offered a copy of consent (for item #12 only, if the client speaks a threshold language, to receive credit for this item, the consent or related progress note contains a statement to indicate "the client was offered a copy of

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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).

63. E/M progress notes are compliant with E/M documentation standards?[5]

PROGRESS NOTES:

The following questions are used to assess compliance with various required components of progress notes and to determine if the narrative within progress notes demonstrates ongoing medical necessity and that proper care was provided to the beneficiary.

64. The progress note demonstrates that the focus of the 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;

    If EPSDT: MH condition can be corrected or ameliorated.[5] [DHCS reason for recoupment #5: *CCR, Title 9, chapter 11, Section 1830.205(b)(3)(A); CCR, Title 9, chapter 11, Section 1840.112(b)(4)*]
65. The progress note demonstrates the expectation that the proposed intervention will do, at least, one of the following:
    - Significantly diminish the impairment;
    - Prevent significant deterioration in an important areas of life functioning;
    - Allow the child to progress developmentally as individually appropriate; or

    For EPSDT, correct or ameliorate the condtion.[5] [DHCS reason for recoupment #6: *CCR, Title 9, chapter 11, Section 1830.205(b)(3)(B); CCR, Title 9, chapter 11, Section 1810.345(c)*]
66. The progress note describes how services provided to the client reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a client's (under age of 21) mental health condition?[5] [DHCS reason for recoupment #7: *MHP Contract, Exhibit A, Attachment 9*]
67. There is a progress note for every service claimed?[5] (For Day Rehabilitation services a Weekly progress note is required). [DHCS reason for recoupment #8: *CCR Title 9,*

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Sections 1840.316 - 1840.322, and 1810.440(c), CCR, Title 22, Section 51458.1(a)(3)(4); MHP Contract ; CCR, Title 9, Section 1840.112(b)(3)]

68. Correct CPT & INSYST service codes?[5] [DHCS reason for recoupment #8: *CCR Title 9, Sections 1840.316 - 1840.322, and 1810.440(c), CCR, Title 22, Section 51458.1(a)(3)(4); MHP Contract ; CCR, Title 9, Section 1840.112(b)(3)*]
69. Date of service is indicated and correct?[5] (For Day Rehabilitation services a Weekly progress note with corresponding dates of services is required) [DHCS reason for recoupment #8: *CCR Title 9, Sections 1840.316 - 1840.322, and 1810.440(c), CCR, Title 22, Section 51458.1(a)(3)(4); MHP Contract ; CCR, Title 9, Section 1840.112(b)(3)*
70. Location of service is indicated and correct?[5]
71. Face-to-face and total time are both documented?[5] [DHCS reason for recoupment #13: *CCR, Title 9, Section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, Section 7.5.5.; MHSUDS Information Notice 17-040]*
72. Total number of providers and their specific involvement in providing the service is documented?[5] [DHCS reason for recoupment #13: *CCR, Title 9, Section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, Section 7.5.5.; MHSUDS Information Notice 17-040]*
73. Total number of clients participating in the service activity is documented?[5] [DHCS reason for recoupment #13: *CCR, Title 9, Section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, Section 7.5.5.; MHSUDS Information Notice 17-040]*
74. Time documented on the progress note equals the time claimed?[5] [DHCS reason for recoupment #8: *CCR Title 9, Sections 1840.316 - 1840.322, and 1810.440(c), CCR, Title 22, Section 51458.1(a)(3)(4); MHP Contract ; CCR, Title 9, Section 1840.112(b)(3)*]
75. Time noted for documentation of services is reasonable?[5] [DHCS reason for recoupment #8: *CCR Title 9, Sections 1840.316 - 1840.322, and 1810.440(c), CCR, Title 22, Section 51458.1(a)(3)(4); MHP Contract ; CCR, Title 9, Section 1840.112(b)(3)*]
76. Documentation content supports amount of direct service time claimed?[5] [DHCS reason for recoupment #8: *CCR Title 9, Sections 1840.316 - 1840.322, and 1810.440(c), CCR, Title 22, Section 51458.1(a)(3)(4); MHP Contract ; CCR, Title 9, Section 1840.112(b)(3)*]
77. Progress note includes a description of that day's presenting problem/evaluation/behavioral presentation or purpose of service?[5]
78. Progress note is legible?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
79. Progress note includes a description of that day's response to interventions?[5] [DHCS reason for recoupment #7: *MHP Contract, Exhibit A, Attachment 9*]

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80. Progress note includes a description of client's and/or staff's plan/follow-up including referrals to community resources and other agencies and any follow up care when appropriate?[5]
81. Claim is not a planned service provided before the completion of the Assessment or without a current (not expired) Assessment?[5] [DHCS reason for recoupment #2: *MHP Contract, Exhibit A, Attachment 2*]
82. Claimed service is not a planned service before the completion of the Client Plan or without a current (non-expired) Client Plan?[5] [DHCS reason for recoupment #4: *MHP Contract.; State Plan, Section 3 to Att. 3.1-A (SPA 12-025, page 2c; MHSUDS Information Notice 17-040*]
83. If a group progress note, the time is properly apportioned to all clients present?[5] [DHCS reason for recoupment #12: *CCR, Title 9, Section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, Section 7.5.5.; MHSUDS Information Notice 17-040*]
84. Services are related to a current mental health objective(s) listed in the Client Plan?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
85. Unresolved Issues from prior services addressed, if applicable?[1]
86. Progress note is signed?[5] [DHCS reason for recoupment #14: *MHP Contract; MHSUDS Information Notice 17-040*]
87. Progress note is dated?[5]
88. Progress note signature contains Medi-Cal designation: Licensed/registered/waivered/MHRS/Adjunct?[5]
89. Service provided within the scope of practice of the person delivering the service?[5] [DHCS reason for recoupment #16: *CCR, Title 9, Section 1840.314(d); MHSUDS Information Notice 17-040*]
90. Progress note contains a completion line after signature (N/A if EHR notes)?[5]
91. Service provided while client was not in a lock-out?[5] [DHCS reason for recoupment #9: *CCR, Title 9, chapter 11, Section 1840.312(g-h); CCR, Title 9, chapter 11, Sections 1840.360- 1840.374; Code of Federal Regulations (CFR), Title 42, part 435, Sections 435.1008 – 435.1009; CFR, Title 42, Section 440.168; CCR, Title 22, Section 50273(a)(1-9); CCR, Title 22, Section 51458.1(a)(8); United States Code (USC), Title 42, chapter 7, Section 1396d*]

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92. Service provided while client was not in juvenile hall?[5] [DHCS reason for recoupment #10: *Code of Federal Regulations, Title 42, Sections 435.1009 – 435.1010; CCR, Title 22, Section 50273(a)(5-8), (c)(1, 5)*]
93. Service provided was not for academic/educational, vocational, recreation and/or socialization?[5] [DHCS reason for recoupment #11: *CCR, Title 9, Sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); Title 22, chapter 3, Section 51458.1(a)(5),(7)*]
94. Service was not transportation related?[5] [DHCS reason for recoupment #11: *CCR, Title 9, Sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); Title 22, chapter 3, Section 51458.1(a)(5),(7)*]
95. Service was not clerical related?[5] [DHCS reason for recoupment #11: *CCR, Title 9, Sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); Title 22, chapter 3, Section 51458.1(a)(5),(7)*]
96. Service was not payee related?[5] [5] [DHCS reason for recoupment #11: *CCR, Title 9, Sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); Title 22, chapter 3, Section 51458.1(a)(5),(7)*]
97. The case was open to the provider at the time of service?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
98. The client was not deceased at the time of service?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
99. The service was not a non-billable activity for completion of the ACBH Screening Tool?[5](if the Screening Tool is integrated into the Assessment, the time can be claimed) [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
100. The progress note does not indicate a duplication of services?[5] [DHCS reason for recoupment # 8; #13: *CCR Title 9, Sections 1840.316 - 1840.322, and 1810.440(c), CCR, Title 22, Section 51458.1(a)(3)(4); MHP Contract ; CCR, Title 9, Section 1840.112(b)(3); CCR, Title 9, Section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, Section 7.5.5.; MHSUDS Information Notice 17-040*]
101. The service was not supervision related?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]

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102. If the progress note documents a discharge note/summary, it is only billed as part of a billable service with the client present OR it contains activity for referral purposes?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
103. The progress note is finalized within five (5) business days?[5]
104. If the progress note is late, “late note” is indicated in the body of the progress note?[5]
105. The claimed service was not (solely or without time apportioned) for housing support without justification for case management?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
106. The claimed service was not for no-show activity?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
107. The claimed service was not for a non-therapeutic mandated reporting activity (written and/or telephone CPS/APS report)?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
108. The claimed service was not (solely or in part without time apportioned) for writing reports for non-clinical treatment purposes (SSI, CFS, etc)?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
109. The claimed service was not interpretation related (solely or in part?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
110. The claimed service was not for a review of medical records without clinical justification and/or documentation of relevant content found?[5] [DHCS reason for recoupment #15: *CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1*]
111. Progress note documents the language that the service is provided in (or note in the Assessment that the client is English-speaking and all services to be provided in English)?[5]
112. Progress note indicates interpreter services were used, and relationship to client is indicated if applicable?[5]

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113. For brokerage/case management progress notes, the required documentation components are present?[5]

CHART MAINTENANCE:

The following questions are used to assess compliance with various required components of Medical Records/Chart Maintenance.

114. Admission date is noted correctly?[1](EOD date in chart should match InSyst).
115. Emergency contact information is in a designated location in the file/HER and at a minimum on the InSyst Face Sheet?[1]
116. Releases of Information (ROI) are present when applicable?[3]
117. Writing is legible?[4] (areas reviewed: Assessments, Client Plans, non-clinical forms progress notes, and MD documents)
118. Signatures are legible (or printed name under signature or signature sheet)?[4] (areas reviewed: Assessments, Client Plans, non-clinical forms, progress notes, and MD documents)
119. When done, service-related client (personal) correspondence is provided in the client's preferred language?[1]
120. When indicated, treatment specific information is provided to the client in an alternative format (e.g. Braille, audio, large print, etc.)?[1]
121. Filing is done appropriately?[1]
122. Client identification is present on each page in the clinical record? (areas reviewed: Assessment, Client Plans, non-clinical forms, PN's, MD documents)[4]
123. If the client has been discharged, the date indicated in the discharge note/summary matches the date in InSyst?[1]
124. The documentation in the chart does not contain significant cut and paste activity?[4] (areas reviewed: Assessment, Client Plans, non-clinical forms, PN's, MD documents)
125. The documentation in the chart uses only county-designated acronyms and abbreviations?[1]

DAY REHABILITATION/DAY TREATMENT:

Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

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Exhibit 1: Quality Review Key SOC 2020 Audit

The following questions are used to assess compliance with various required components associated with Day Rehabilitation and Day Treatment Service modalities. These types of services have additional documentation and service requirements.

126. The documentation in the chart uses only county-designated acronyms and abbreviations?[1]
127. Do all of the Written Weekly Schedules for the audit period show that a community meeting has occurred at least once a day?[1]
128. Do all of the Written Weekly Schedules for the audit period show that the community meeting included a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker or marriage and family therapist; or a registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist?[1]
129. Do all of the Written Weekly Schedules for the audit period show that the therapeutic milieu includes Process Groups?[1] Process groups shall assist each client to develop necessary skills to deal with his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. (Day Rehabilitation may include psychotherapy instead of process groups, or in addition to process groups)
130. Do all the Written Weekly Schedules for the audit period show that the therapeutic milieu includes Skill Building Groups?[1]
131. Do all he Written Weekly Schedules for the audit period show that the therapeutic milieu includes Adjunctive Therapies?[1]
132. Documentation reviewed, including the written weekly schedule for DTI/DR along with the progress notes, reflects the program met the time requirements for a half-day or full-day program as follows:
    - Breaks and/or meal times were not counted in order to meet the time requirements
    - Half day program was for 4 hours or less, but a minimum of 3 hours
    - Full day program was more than four hours.[1] [DHCS reason for recoupment #19: *CCR, Title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040*]
133. On a day when the client 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 documentation of the reason for an "unavoidable absence" which clearly

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Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

Scoring Key:

[1] ***Yes=100% No=0%:*** *These quality review items have either a 'Yes' or 'No' answer*

[2] ***True=100% False=0%:*** *These quality review items have either a 'True' or 'False' answer*

[3] ***# present/total required:*** *These quality review items can score from a range of 0-100%*

[4] ***# of items or areas compliant/# items or areas evaluated****: These quality review items can score from a range of 0-100%*

[5] ***% of those audited that are compliant:*** *These quality review items can score from a range of 0-100%*

explains why the client could not be present for the full program on the day claimed?[1] [DHCS reason for recoupment #17: *CCR, Title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;*]

134. The actual number of hours and minutes the client attended the DRI/DR program (e.g., 3 hours and 58 minutes) is documented?[1] [DHCS reason for recoupment #18: *DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;*]
135. Required DTI/DR documentation was present as follows:
    - There is a clinical summary present for Day Treatment for the day of the service reviewed
    - There is a daily progress note present for Day Treatment for the day of the service reviewed
    - There is a weekly progress note present for Day Rehabilitation for the week of the service reviewed[1] [DHCS reason for recoupment #20: *CCR, Title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040*]
136. If absences are frequent, does the documentation show that the provider has re-evaluated the client's need for Day Rehabilitation and has taken appropriate action?[1]
137. Does the documentation show that there was at least one contact per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a minor client, that focuses on the role of the support person in supporting the client's community reintegration; and that this contact occurred outside the hours of operation?[1]
138. Does the documentation for the audit period show there is at least one staff person present and available to the group in the therapeutic milieu?[1]
139. Does the documentation for the audit period show: For Day Rehab: there is an average ratio of at least one person from the following list providing services to ten clients in attendance during the period the program is open:
    1. Physicians, 2. Psychologists or related waivered/registered professionals, 3. LCSWs or related waivered/registered professionals, 4. LMFTs or related waivered/registered professionals, 5. registered nurses, 6. licensed vocational nurses, 7. psychiatric tech, 8. Occupational therapists, 9. MHRSs
    Day Rehab - For programs serving more than 12 clients there is at least two of the following:
    1. Physicians, 2. Psychologist or related waivered/registered professionals, 3. LCSWs or relates waivered/registered professionals, 4. LMFTs or related

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Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

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waivered/registered professionals, 5. registered nurses, 6. licensed vocational nurses, 7. psychiatric tech, 8. MHRSs.
For Day Treatment Intensive: there is an average ratio of at least one person from the following list providing DTI services to eight clients in attendance during the period the Program is open:
1. Physicians, 2. Psychologists or related waivered/registered professionals, 3. LCSWs or related waivered/registered professionals, 4. LMFTs or related waivered/registered professionals, 5. registered nurses, 6. licensed vocational nurses, 7. psychiatric tech, 8. Occupational therapists, 9. MHRSs
Day Treatment Intensive - For programs serving more than 12 clients there is at least one person from EACH OF TWO of the following groups:
1. Physicians, 2. Psychologists or related waivered/registered professionals, 3. LCSWs or related waivered/registered professionals, 4. LMFTs or related waivered/registered professionals, 5. registered nurses, 6. licensed vocational nurses, 7. psychiatric tech, 8. Occupational therapists, 9. MHRSs[1]

140. Is there a Written Program Description which describes the specific activities of each service and reflects each of the required components of the services?[1]
141. Is there a Written Weekly Schedule for the audit period which identifies when and where the service components will be provided and by whom?[1]
142. Does the Written Weekly Schedule for the audit period list the program staff, their qualifications, and the scope of their services?[1]
143. If the Provider uses staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), is there documentation for the audit period of the scope of responsibilities for these staff and the specific times in which Day Rehabilitation activities are being performed exclusive of other activities?[1]
144. Is there a Mental Health Crisis Protocol?[1]
145. Does the documentation show that services were authorized in advance if provided more than five days per week?[1]
146. Does the documentation show that services were authorized at least every 6 months for continuation – at least every 6 months for Day Rehab and at least every 3 months for DTi?[1]
147. Does the documentation show that the provider requested authorization for mental health services (i.e. Med Support Svcs) provided concurrently with Day Rehab/DTi, excluding services to treat emergency and urgent conditions?[1]

Quality Review Items which are also reasons for disallowances indicate the DHCS reason and *regulation*.

Scoring Key:

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[5] ***% of those audited that are compliant:*** *These quality review items can score from a range of 0-100%*