Mental Health System of Care Audit of ACBH Contracted Programs

Audit Performed in 4th Quarter of 2019
For Audit Period: 10/1/2018 – 12/31/2018

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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) requested a random sample of all submitted MH claims for the time period of 10/1/2018 -12/31/2018 from Emanio (database which pulls information from the InSyst Medi-Cal claiming program) for adult and child Medi-Cal beneficiaries. Twenty (20) charts from twenty (20) providers and a total of two-hundred and ninety-two (292) claims were reviewed for compliance and quality of care utilizing a standardized chart audit protocol.

Exhibit 1 includes the claims that were reviewed by client chart and by provider. Exhibit 2 lists the DHCS Reasons for Recoupment with ACBH Claims Comments for FY 2016-2017. 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:

Please refer to the Claims Review Spreadsheet (Exhibit 1), the DHCS Reasons for Recoupment with ACBH Claims Comments for FY 2016 – 2017 (Exhibit 2) while reviewing this section. Overall, of the 292 total claims examined by QA clinical staff, 190 claims (65%) met the documentation standards and 102 claims (35%) were disallowed because they did not meet the standards.

The claims compliance of 65% is slightly lower compared to the Q4 2018 SMHS SOC Audit that had a compliance rate of 70%.

In the next section we describe in detail the claims compliance findings by providers' age group served, by dollar amount, by chart, by provider, by reason for recoupment of paid claims, and by service modality. Table #1 below specifies claims compliance by providers' age group served. Providers serving adults had a similar, but slightly higher, compliance percentage compared with those providers serving children.

Table #1: Claims Compliance by Providers				
Providers	**Number of Claims**	**Allowed Claims**	**Disallowed Claims**	**Percent Compliant**
All	292	190	102	65%
Child Providers	144	111	69	77%
Adult & Older Adult Providers	148	79	69	53%

The total number of claims reviewed was four hundred eighty-four (484) with a total service cost of $184,687.64. The total number of allowed claims was three hundred and forty-one (341) with a total service cost of $123,069.90. The total number of disallowed claims was one hundred and forty-three (143) with a total service cost of $61,617.74. Please see Table #2 (Claims Compliance by Dollar Amount) below**.**

See Table #2: Claims Compliance by Dollar Amount		
Claims	**Amount**	**Dollars**
Total	292	$73,189.20
Allowed	190	$46,524.07
Disallowed	102	$26,665.13

Due to non-compliance with Mental Health Assessments and/or Client Plans, additional claims outside of the audit period were also subject to disallowance. The additional disallowances are noted in the Addendum (by Provider) and totaled $14,148.50.

The *average claims compliance per provider* indicated that 15% of chart/providers (3 of 20) scored in the compliance range of 95% or higher, 30% of the providers (6 of 20) scored in the compliance range of 85% - 94%, 10% of providers (2 of 20) scored in the compliance range of 75%-84%, 0% of the providers (0 of 20) scored in the compliance range of 65% - 74%, and 45% (9 of 20) scored in the compliance range of 65% or less. See Table #4 (Claims Compliance Results by Provider) below:

Table #4: Claims Compliance Results by Chart/Provider		
Number of Providers	**Average Chart Compliance %**	**Percentage of Total**
3	95%-100%	15%
6	85%-94%	30%
2	75%-84%	10%
0	65%-74%	0%
9	< 65%	45%

The ACBH reasons for claims disallowances in this audit are listed below. Please refer to Exhibit #2: DHCS Reasons for Recoupment with ACBH Claims Comments for FY 2017-2018 for

categories of claims disallowances. See Table #5 (Reasons for Recoupment of PAID Claims by Frequency) below:

	Table #5: Reasons for Recoupment of PAID Claims by Frequency			
DHCS Reasons for Recoupment	**Reason for Recoupment**	**Type of Service**	**Frequency**	**% of Reasons for Disallowance**
1a, 2, 3, 4	Before Planned Services have been provided (without an Assessment or Interim Assessment) where full Medical Necessity has not been established in each Planned Services Progress Note (by Licensed LPHA or Waivered/Registered LPHA with Licensed LPHA co-signature)	Assessment	0	0%
1b, 2, 3, 4	Planned Services have been provided (without an Assessment or Interim Assessment completed).	Assessment	0	0%
1c, 2, 3, 4	Assessment or Interim Assessment not signed by Licensed/Waivered/Registered LPHA, or Trainee with Licensed LPHA co-signature	Assessment	0	0%
1d, 2, 3, 4	Non-Included Diagnosis.	Assessment	0	0%
1e, 2, 3, 4	a) Documentation in the Assessment or Interim Assessment does not support the included diagnosis. (DSM Diagnostic Criteria is not met, or adequately documented, for a Medi-Cal Included Diagnosis, the Assessment or Interim Assessment does not contain mental status exam.)	Assessment	18	12%
1f, 2, 3, 4	Diagnosis is not established by	Assessment	15	10%

	licensed LPHA OR not co-signed by licensed LPHA if established by a waivered staff or registered intern, or second year graduate trainee/student with appropriate training and experience and licensed supervisor attestation			
2, 3, 4	Documentation in the medical record does not establish that impairment to functioning is due to the included diagnosis	Assessment	0	0%
3, 4	Documentation in the medical record does not establish that the focus of the proposed intervention is to address the conditions identified as a result of the included diagnosis	Assessment	0	0%
4	Documentation in the medical record does not establish the expectation that the proposed intervention will improve or ameliorate the conditions identified as resulting from the included diagnosis or the condition could be treated in a physical health care based setting only	Assessment	0	0%
5a	A planned SMHS is provided before the Initial Client Plan is completed and medical and service necessity for the planned service is not documented in the completed mental health assessment. Note: Per DHCS Info Notice 17-040 no planned services can ever be provided before completion of a treatment plan. This take effect in ACBH on 3/1/2018.	Client Plan	4	3%

5b 6b	No Initial or Annual Client Plan.	Client Plan	4	3%
5c 6c	Initial or Annual Client Plan is late and planned services were provided during period of time where there is not an active treatment plan.	Client Plan	0	0%
5d 6d	Initial or Annual Client Plan is missing required staff signature(s) for date of service.	Client Plan	0	0%
5e 6e	There is not a current (not expired) mental health objective in the Initial or Annual Client Plan.	Client Plan	20	13%
5f 6f	Service modality claimed is not indicated in Initial or annual Client Plan.	Client Plan	3	2%
6g	Plan is not updated (re-written) when clinical need arises.	Client Plan	3	2%
7a	No client (or guardian) signature on Client Plan for date of service, w/o documentation of reason	Client Plan	0	0%
7b	Late client (or guardian) signature on Client Plan for date of service, w/o documentation of reason.	Client Plan	0	0%
8a	Documentation of TBS Class Certification is not in the chart and is not provided upon request. TBS Class Certification requires Medi-Cal beneficiaries be under the age of 21 and meet one of the following criteria: Is placed in RCL 12 or above and/or another locked treatment facility for the treatment of mental health needs; Is being considered for placement in a locked treatment facility; Is at	TBS	0	0%

	risk of psychiatric hospitalization; Has been psychiatrically hospitalized in the past 24 months; Previously received TBS while a member of the certified class.			
8b	No TBS Plan (or not within Client Plan).	TBS	0	0%
8c	The TBS Plan (or Client Plan) does not document: 1) Specific target behaviors or symptoms that are jeopardizing the current place of residence or presenting a barrier to transitions (e.g. temper tantrums, property destruction, and assaultive behavior in school). 2) Specific interventions to resolve behaviors or symptoms, such as anger management techniques. 3) Specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and has been replaced by adaptive behaviors. 4) A transition plan from the inception of TBS to decrease or discontinue TBS when these services are no longer needed or when the need to continue TBS appears to have reached a plateau in benefit effectiveness.	TBS	0	0%
9	No Progress Note was found for service claimed	Progress Notes	13	8%
10a	Documentation content does not support amount of time	Progress Notes	14	9%

	claimed			
10b	Time documented on Progress Note does not equal time claimed (overbilled)	Progress Notes	1	1%
10c	Written documentation does not support documentation time claimed or documentation time is excessive	Progress Notes	8	5%
10d	Time on Progress Note is not broken down into face-to-face and total time (for time based codes—crisis, ind. psychotherapy, E/M when > 50% of face-to-face time is spent as Counseling & Coordination of Care).	Progress Notes	0	0%
11	The Progress Note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation.	Progress Notes	0	0%
12	The Progress Note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).	Progress Notes	0	0%
13a	The Progress Note indicates that the service provided was Academic educational service.	Progress Notes	0	0%
13b	The Progress Note indicates that the service provided was for vocational service that has work or work training as its actual purpose.	Progress Notes	1	1%
13c	The Progress Note indicates that the service provided was	Progress Notes	0	0%

	recreational related.			
13d	The Progress Note indicates that the service provided was social group related.	Progress Notes	0	0%
14a	Group service note does not include # of clients served.	Progress Notes	0	0%
14b	Group service note does not include # of staff present.	Progress Notes	0	0%
14c	Group Time claimed is inaccurately calculated.	Progress Notes	0	0%
15a	Progress note is missing service provider signature.	Progress Notes	0	0%
15b	Progress note is missing required LPHA co-signature.	Progress Notes	0	0%
16	Non-billable activity: transportation related	Progress Notes	0	0%
17a	Non- billable electronic-type activity – voicemail/email/text/IM, etc.	Progress Notes	1	1%
17b	Non- billable activity – scheduling appointment related.	Progress Notes	0	0%
17c	Non- billable activity – Other clerical/administrative related.	Progress Notes	0	0%
18	The progress note indicates the service provided was solely payee related.	Progress Notes	1	1%
19a1	SMHS claimed does not match type of SMHS documented	Progress Notes	16	10%
19a2	Progress Note does not include required components: a) service being addressed the day of Medi-Cal claim is associated with an existing (current – not expired) MH Objective in the Client Plan, b) Staff's Mental Health Intervention for the date of service, c) Client's response to that day's Staff Intervention.	Progress Notes	0	0%
19a3	Progress Note includes extensive cut & paste activity for: Staff's Intervention, OR	Progress Notes	1	1%

	Client's Response to Staff Intervention.			
19a4	Case closed, cannot bill.	Progress Notes	0	0%
19a5	Client deceased, cannot bill.	Progress Notes	0	0%
19a6	Non SMHS Service Intervention: a) service is a Non-MH one, b) the completed Brief Screening Tool (Mild-Moderate vs. Moderate-Severe) for a client 18 years and older indicated that they should have been referred to a Mild-Moderate Provider.	Progress Notes	9	6%
19a7	Illegible Progress Note	Progress Notes	0	0%
19a8	Duplication of Services: a) same service billed twice by same provider, b) same service by different providers without documentation to support co-staffing.	Progress Notes	7	4%
19a9	Non billable activity - Time claimed includes supervision related activities.	Progress Notes	3	2%
19a10	Day Rehabilitation / Day Treatment Intensive did not include all the required service components.	Progress Notes	0	0%
19a11	The total number of minutes/hours the client actually attended Day Rehabilitation / Day Treatment Intensive were not documented.	Progress Notes	0	0%
19a12	The client did not receive the minimum required hours in order to claim for full or half Day Rehabilitation / Day Treatment Intensive services.	Progress Notes	0	0%
19a13	Day Rehabilitation / Day	Progress	0	0%

	Treatment Intensive did not include all program requirements (program/group descriptions, weekly calendar, etc.).	Notes		
19a14	Non-billable activity – housing support related (solely or in part without time apportioned).	Progress Notes	0	0%
19a15	Non-billable activity – No show	Progress Notes	7	4%
19a16	Non-billable activity – Non-therapeutic mandated reporting – written and/or telephone (CPS/APS) (solely or in part without time apportioned).	Progress Notes	0	0%
19a17	Writing reports for non-clinical treatment purposes (SSI, CFS, etc.) (Solely or in part without time apportioned).	Progress Notes	0	0%
19a18	Non-billable activity – Interpretation related (solely or in part). If staff is interpreting, no other services may be claimed by that person.	Progress Notes	0	0%
19a19	Review of medical records without clinical justification and documentation of relevant content found.	Progress Notes	0	0%
19a20a	Area of Case Management need is not indicated in Assessment, Client Plan, or Progress Note(s) as required.	Progress Notes	3	2%
19a20b	Medical need for Case Management is not supported in Assessment, Client Plan, or Progress Note(s) as required: Record indicates for clients ≥18 years – symptoms/impairments of Included Diagnosis prevent	Progress Notes	2	1%

	client from utilizing community supports in Case Management area of need OR for clients <18 years, area of need (housing, medical, educational, SUD, etc.) exacerbates client's symptoms/impairments of Included Diagnosis.			
19a20c	Service need for Case Management is not supported in Assessment, Client Plan, or Progress Note(s) as required: Record indicates successful result of Case Management services (now housed, receiving medical care, etc.) will decrease client's symptoms/impairments of Included Diagnosis).	Progress Notes	2	1%
19b	Service was claimed for a provider on the Office of Inspector General List of Excluded Individuals and Entities.		0	0%
19c	Service was claimed for a provider on the Medi-Cal suspended and ineligible provider list.		0	0%
19d	Service was not provided within the scope of practice of the person delivering the service.		0	0%
20a	For beneficiaries receiving TBS, the TBS Progress Notes overall clearly indicate that TBS was provided for convenience of the family, caregivers, physician, or teacher.	TBS	0	0%
20b	For beneficiaries receiving TBS, the TBS Progress Notes overall clearly indicate that	TBS	0	0%

	TBS was provided for purpose of client/youth supervision or to ensure compliance with terms and conditions of probation.			
20c	For beneficiaries receiving TBS, the TBS Progress Notes overall clearly indicate that TBS was provided for purpose of ensuring the child's/youth's physical safety or the safety of others, e.g., suicide watch.	TBS	0	0%
20d	For beneficiaries receiving TBS, the TBS Progress Notes overall clearly indicate that TBS was provided to address conditions that are not part of the child's/youth's mental health condition	TBS	0	0%
21	For beneficiaries receiving TBS, the Progress Note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.	TBS	0	0%
Totals			156	100%*

*based on rounding off percentage numbers

The reasons for claims disallowances may be grouped into categories.

<u>Twenty-one (21%) of the reasons for disallowance were related to the Mental Health Assessment requirements for the following reasons</u>:
No Assessment was present (or that meets medical necessity for a planned service) for date of service; an Assessment was past due; an Assessment was not signed by Licensed/Waivered/Registered LPHA (including the diagnosis was not established by licensed LPHA or not co-signed by licensed LPHA if it was established by a waivered staff or registered intern), or MH Trainee with a licensed LPHA co-signature; there was a non-included diagnosis; full Medical Necessity had not been established for a Planned Service Modality; Planned Services had been provided where full Medical Necessity had not been established in each Planned Services Progress Note (by Licensed LPHA or Waivered/Registered LPHA with Licensed LPHA co-signature).

Twenty-two (22%) of the reasons for disallowance were related to the Client Plan requirements for the following reasons:
A Planned Service is provided before the Initial Client Plan completion date, and medical and service necessity for the Planned Service is not documented in the completed Mental Health Assessment; Service Modality claimed is not indicated in the Initial or Annual Client Plan; no client (or guardian) signature on the Client Plan for date of service, without documentation of reason why.

Fifty-seven percent (57%) of the reasons for disallowance were related to Progress Notes requirements for the following reasons:
No Progress Note was found for service claimed; documentation content does not support amount of time claimed; time documented on Progress Note does not equal time claimed (overbilled); documentation does not support documentation time claimed or documentation time is excessive Progress Note indicates that the service provided was an academic or educational service; non- billable activity – scheduling appointment related; SMHS claimed does not match type of SMHS documented; Progress Note does not include required components: a) service being addressed the day of Medi-Cal claim is associated with an existing (current – not expired) MH Objective in the Client Plan, b) staff's mental health intervention for the date of service, c) client's response to that day's staff intervention; non SMHS Service Intervention: a) service is a non-MH one, b) the completed Brief Screening Tool (Mild-Moderate vs. Moderate-Severe) for a client 18 years and older indicated that they should have been referred to a Mild-Moderate Provider; duplication of Services: a) same service billed twice by same provider, b) same service by different providers without documentation to support; non billable activity - time claimed includes supervision related activities; area of Case Management need is not indicated in Assessment, Client Plan, or Progress Note(s) as required.

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

Table #6: Reasons for Claims Disallowances	
Reasons Category	**Percent of Disallowance Reasons**
Mental Health Assessment	21%
Client Plan	22%
Progress Notes	57%

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

Table #7: Percentage of Modality types Disallowed			
Disallowed MH Services by Modality	**Number of Claims Disallowed**	**Total Number of Claims (by type) across all charts audited.**	**Percentage of Claims Disallowances by Modality Type**
Family Therapy	0	7	0%
Evaluation/Assessment	10	64	16%

Medication Management/E&M	6	27	22%
Individual Psychotherapy	10	39	26%
Collateral	5	14	36%
Plan Development	9	24	38%
Case Management /Brokerage	15	29	52%
Individual Rehabilitation	31	54	57%
Group Rehabilitation	3	3	100%

<u>QUALITY REVIEW</u>:

The Quality Review determined if the standards for documentation of Medi-Cal Specialty Mental Health Services had been met. Thirteen (13) Quality Review areas, with 195 Quality Review Items (QRIs), were analyzed in this audit. They included: *Screening (Mild-Moderate-Severe), Informing Materials, Interim Assessments, Assessments, Client Plans, TBS, Special Needs, Medication Log and Consents, Progress Notes, and Chart Maintenance. Note that Day Rehabilitation, Psychiatric Emergency services, and site certification compliance was not reviewed for this audit.*

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

Please note that the Quality Review Items (QRIs) are inclusive of reasons for claims disallowances. Not all QRIs are reasons for disallowance—see Quality Review Item (QRI) descriptions in this report (or Exhibit 4) for those that are also a reason for claims disallowance and recoupment.

As you read the report you will find percentages for each QRI which represents the ratio of *adherence* with required chart documentation. Following each of the QRIs there is a reference for the corresponding QRI Number (QRI #) listed in (Exhibits 3 & 4).

QRIs were evaluated from either a categorical or stratified approach. Most of the QRIs required a categorical method resulting in either a 'Yes/No' or 'True/False' review~~.~~ In these items, the scores are either 100% for Yes/True or 0% for No/False. Wherever possible, scoring for a QRI was stratified allowing for a more accurate portrayal of documentation compliance.

The stratified approach is described in the example below:

- *QRI # 75 <u>"There is a Progress Note for every service contact"</u>*:

- *If there were 10 Progress Notes that were claimed during the audit period and 8 were present in the chart, the score for that chart on this item would be 80%. Each chart would be evaluated similarly. Then, the percentages for all charts are averaged to obtain an overall compliance score for that quality review item.*

Some requirements do not apply to specific charts, such as when clients do not receive medication support services or when the client was discharged prior to the due dates for the Assessment or Client Plan. These are noted as 'N/A' in the Quality Review Spreadsheet, and are not incorporated into the final score for that QRI.

It is important to note that some Quality Review items are more crucial than others (i.e. presence of Medi-Cal Included Diagnosis versus appropriate filing of documents within chart sections); therefore examining the score for each individual QRI is more informative and indicative of documentation quality than the overall Quality Review score.

The overall compliance rate for the Quality Review was 87% (see Exhibit 3). The results of the Quality Review for twenty (20) charts demonstrated that 25% of the charts scored in the 95% - 100% range, 50% of the charts scored in the 85% - 94%, 15% of the charts scored in the 75% - 84% range, 0% of the charts scored in the 65% - 74% range, and 10% of the charts scored below 65%. See Table #8: (Quality Review Compliance by Chart) below:

Table #8: Quality Review Compliance by Chart		
Number of Charts	**Quality Compliance Rate**	**Percentage**
5	95% – 100%	25%
10	85% – 94%	50%
3	75% – 84%	15%
0	65% – 74%	0%
2	<65%	10%

- ACBH Screening:
  - 68% (13/19) of the charts had the most recent required 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)
  - 89% (17/19) of the charts showed evidence that the mental health condition meets the criteria for moderate to severe based on the most recent required ACBH Screening Tool, when required per program. (QRI #12)

- <u>ACBH Informing Materials:</u>
    - 70% (14/20) 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, documents reason in Progress Notes. (QRI #13)

- <u>Interim Assessment:</u>
    - QRIs #14 – #17 are all N/A because none of the charts reviewed in this audit contained an Interim Assessment.

- <u>Assessments:</u>
    - 74% (14/19) of the charts had documentation in the Assessment that established a primary diagnosis from the DHCS Medi-Cal Included Diagnosis list **for the full audit period.** (QRI #18)
    - 79% (15/19) of the charts had documentation in the Assessment **for the full audit period** that established that, as a result of the primary diagnosis, there is at least one of the following:
      --Significant impairment in important area of life functioning;
      --Probable significant deterioration in an important area of life functioning;
      --Probable the child won't progress developmentally, as appropriate; or
      --If EPSDT: MH condition can be corrected or ameliorated. (QRI #19)
    - 79% (15/19) of the charts had documentation in the Assessment **for the full audit period** that established that the focus of the proposed intervention addresses the condition of the primary diagnosis as it relates to:
      --Significant impairment in important area of life functioning;
      --Probable significant deterioration in an important area of life functioning;
      --Probable the child won't progress developmentally, as appropriate; or
      --If EPSDT: MH condition can be corrected or ameliorated. (QRI #20)
    - 79% (15/19) of the charts had documentation in the Assessment **for the full audit period** that established the expectation that the proposed intervention will do, at least, one of the following:
      --Significantly diminish the impairment;
      --Prevent significant deterioration in an important area of life functioning;
      --Allow the child to progress developmentally, as appropriate; or
      --If EPSDT: Correct or ameliorate the condition. (QRI #21)
    - 100% (19/19) of the charts had presenting problems and relevant conditions included in the most recent required assessment. (QRI #22)
    - The compliance rate for assessing the four (4) required areas of psychosocial history in the most recent required assessments across all charts was 88% (QRI #23)
        - *The psychosocial history should include: 1) living situation, 2) daily activities, 3) social support, and 4) history of trauma or exposure to trauma.*

- The compliance rate for assessing the four (4) required areas of current and past psychiatric medications (or lack thereof) the client has received in the most recent required assessments across all charts was 75%. (QRI#24)
    - *This item should include: 1) current psychiatric medications, 2) duration of treatment with current psychiatric medications, 3) past psychiatric medications, 4) duration of treatment with past psychiatric medications.*
- The compliance rate for assessing the four (4) required areas of current and past medications to treat medical conditions (or lack thereof) the client has received in the most recent required assessments across all charts was 67%. (QRI #25)
    - *This item should include: 1) current medications to treat medical conditions, 2) duration of treatment with current medications to treat medical conditions, 3) past medications to treat medical conditions, 4) duration of treatment with past medications to treat medical conditions.*
- 84% (16/19) 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 #26)
- 74% (14/19) of the charts included the assessment of risks to client in the most recent required assessment. (For credit, Danger to Self must be assessed and if indicated, a description is required). (QRI #27)
- 68% (13/19) of the charts included the assessment of risks to others in the most recent required assessment. (For credit, Danger to Others must be assessed and if indicated, a description is required). (QRI #28)
- 90% (9/10) of the charts included pre/perinatal events and relevant/significant developmental history for youth in the most recent required assessment. (QRI #29)
- 95% (18/19) 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 #30)
- 95% (18/19) of the charts documented allergies/adverse reactions/sensitivities, or lack thereof, in the record. (QRI #31)
- 89% (17/19) of the charts displayed allergies/adverse reactions/sensitivities, or lack thereof, on the chart cover, or if an EHR it is in the field/location designated by the clinic. (QRI #32)
- 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 82%. (QRI #33)
    - *This item should include: 1) medical conditions, 2) name of current provider, 3) address of current provider.*
- The compliance rate for assessing the four (4) required areas of mental health history (or lack thereof) in the most recent required assessments across all charts was 71%.
  (QRI #34)

        - *This item should include: 1) previous treatment (including inpatient admissions), 2) previous providers, 3) therapeutic modalities, 4) client response to treatment.*
    - The compliance rate for assessing the required seven (7) areas of substance exposure/substance use in the most recent required assessments across all charts was 88%. (QRI #35)
        - *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 94%. (QRI #36)
    - 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 67%. (QRI #37)
    - 89% 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 #38)
        - *This is a crucial item that if not met, results in claims disallowances (until met).*

- Client Plans:
    - 89% of client plans for the audit period were completed and signed on time by all required staff. (QRI #39)
    - 75% 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 #40)
        - *There must be at least one current mental health objective on the Client Plan that addresses the symptoms/impairments of the included diagnosis in order to claim for services. This is a crucial item that if not met, results in claims disallowances (until met).*
    - 74% of the Mental Health Objectives listed in the most recent required Client Plans, across all charts, were observable or measureable with timeframes and preferably baselines. (QRI #41)
    - 96% 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 #42)
        - *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.*
    - 93% 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 #43)

- *All modalities should list the frequency and timeframes (i.e. Psychotherapy 1x/week, **AND** as needed, for 12 months).*

- 94% 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 #44)
    - *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…"*
- 60% (9/15) 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 #45)
- 55% (6/11) 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 #46)
    - *When there is a risk to self or others present within the last 90 days of the service date, there should be a Treatment Plan goal with objectives that address the identified risks, **and** a specific Safety Plan. Progress Notes must also document the ongoing assessment and interventions of these risks.*
- 95% (18/19) of the charts showed evidence of coordination of care when it was applicable. (QRI #47)
- 90% (9/10) 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 #48)
    - *This is a crucial item that results in disallowances for all claimed services after the Client Plan should have been updated.*
- 63% (5/8) of the most recent required Client Plans for the audit period, across all charts, were signed/dated by MD/NP if applicable. (QRI #49)
- 89% 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 #50)
    - *This is a crucial item that if not met, results in claims disallowances for planned services (until met).*
    - *If the client signature was late or not present, the reason must be indicated on the signature line and documented in a Progress Note.*
- 79% (15/19) 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 #51)
    - *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.

- 89% (17/19) 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 #52)
    - *If the client speaks a threshold language, in order to receive credit for this item: The plan or related progress note contains a statement to indicate "the client was offered a copy of the client plan in their threshold language" or a statement to indicate that the provider explained, or offered to explain the plan to the client in their threshold language, or, there should be a copy of the client plan in the client's threshold language. (Threshold languages: Spanish, Cantonese, Mandarin, Farsi, Vietnamese, Korean, Tagalog). If the Client Plan in the record is not in English, an English translation of the Client Plan **must also** be in the client's chart.*
- 74% (14/19) 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 #53)
    - *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.*

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

- QRIs #54 - #62 are all N/A because no charts providing TBS services were reviewed in this audit.

➢ Special Needs:

- 84% (16/19) 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 #63)
- Of those with noted cultural and communication needs, 92% (11/12) of those charts addressed them as appropriate. (QRI #64)
- 72% (13/18) of the most recent required Client Plans or Assessments for the audit period noted client's physical limitations, or lack thereof. (QRI #65)
- Of those with noted physical limitations, 80%) of those charts addressed the physical limitations as appropriate. (QRI #66)

➢ Medication Log Issues:

- 88% (7/8) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which was updated at each visit with date of prescription, when applicable. (QRI #67)

- 88% (7/8) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which was updated at each visit with the drug name, when applicable. (QRI #68)
- 88% (7/8) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which was updated at each visit with the drug strength/size, when applicable. (QRI #69)
- 88% (7/8) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which was updated at each visit with the instruction/frequency for administration of the medication, when applicable. (QRI #70)
- 88% (7/8) of the charts had a Medication Log (or complete medication information in every MD/NP Progress Note) which is updated at each visit with the prescriber's signature or initials, when applicable. (QRI #71)
- 86% of the required Informed Consent for Medication(s) and JUV 220/3 (required for foster children) were completed and signed when applicable. (QRI #72)
    - *This is a significant item that must be addressed for all charts in which psychotropic medications are prescribed.*
- The compliance rate for including the twelve (12) required components of all required Informed Consents for Medication(s) for the audit period, across all charts was 98% (QRI #73)
    - *All Consents for Medication must include: 1) Rx name, 2) specific dose or range, 3) administration route, 4) expected uses/effects (reasons used), 5) short term and long term (beyond 3 months) risks/side effects, 6) available and reasonable alternative treatment, 7) duration of taking the medication, 8) consent once given may be withdrawn at any time, 9) client signature, 10) client name or ID, 11) prescriber signature, 12) indication that the client was offered a copy of consent (for #12 only, if the client speaks a threshold language, the consent or related progress note should contain a statement to indicate "the client was offered a copy of the consent in their threshold language" or a statement to indicate that the provider explained, or offered to explain the consent to the client in their threshold language, or, there should be a copy of the consent in the client's threshold language).*
- 100% for the E/M Progress Notes. (QRI #74)
    - *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.*)

- There was a Progress Note for 95% of all service contacts. (QRI #75)
- 90% of the Progress Notes had the correct CPT Code/exact procedure name, and/or INSYST service code for the mental health services provided. (QRI #76)
    - *This is a crucial item that if not met, results in claims disallowances.*

- 95% 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 #77)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 88% of the Progress Notes indicated the correct location of service. (QRI #78)
- 96% of the Progress Notes documented both face-to-face time and total time. (QRI #79)
  - *For service codes that are time based--this is a crucial item that if not met, results in claims disallowances.*
- 94% of the Progress Notes documented time that equaled the time that was claimed. (QRI #80)
  - *This is a crucial item that if not met, results in claims disallowances.*
- 91% of the Progress Notes had reasonable time noted for documentation. (QRI #81)
  - *This is a crucial item that if not met, may result in claims disallowances.*
- 87% of the Progress Notes had documented content that supported the amount of direct service time claimed. (QRI #82)
  - *This is a crucial item that if not met, may result in claims disallowances.*
- 94% 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 #83)
- 95% of the Progress Notes included a description of a staff specialty mental health service (SMHS) **I**ntervention for that day's service. (QRI #84)
  - *This is a crucial item that if not met, results in claims disallowances.*
  - *Interventions must be related to client's diagnosis, symptoms, impairments, and mental health objectives listed in Client Plan.*
- 95% of the Progress Notes establishes that the focus of the actual intervention addresses the condition of the primary diagnosis as it relates to: (QRI #85)
  -- 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.
- 95% of the Progress Notes establishes that the focus of the actual intervention will do, at least, one of the following: (QRI #86)
  -- Significantly diminish the impairment
  -- Prevent significant deterioration in an important area of life functioning;
  -- Allow the child to progress developmentally, as appropriate;
  -- For EPSDT: Correct or ameliorate the condition.
- 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 #87)

- 84% 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 #88)
    - **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 treatment plan. (For this audit, a completed mental health assessment that included medical and service necessity for the planned service was considered in compliance. Per ACBH memo dated 2/23/18 no planned services can be provided before the completion of a client's treatment plan (effective 3/1/2018). (QRI #89)
- 100% of the group service Progress Notes included correct calculation of the time and listed the number of clients served. (QRI #90)
    - *This is a crucial item that 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 #91)
    - *This is a crucial item that if not met, may result in claims disallowances.*
- 90% (9/10) of the charts contained documentation that addressed unresolved issues from prior services, when applicable. (QRI #92)
- 95% of the Progress Notes were signed. (QRI #93)
- 91% of the Progress Notes signatures included the date. (QRI #94)
- 92% of the Progress Notes signatures included the staff Medi-Cal designation (may also list credential on Provider Signature Page/Sheet in chart). (QRI #95)
    - *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).*
- 33% of the Progress Notes required to have the completion line after the signature were compliant. (QRI #96)
- 95% 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 #97)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 96% of the claimed services were NOT provided while the client was in juvenile hall (unless documentation of an adjudication order is obtained) (QRI #98)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 95% 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 #99)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 95% of the claimed services provided were NOT transportation related. (QRI #100)

    - *This is a crucial item that if not met, results in claims disallowances.*
- 95% of the claimed services provided were NOT clerical related. (QRI #101)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 95% of the claimed services provided were NOT payee related. (QRI #102)
    - *This is a crucial item that if not met, results in claims disallowances.*
- 100% of the claimed services were provided when the case was open to the provider. (QRI #103)
- 100% of the claimed services were provided when the client was NOT deceased. (QRI #104)
- 95% of the claimed services provided were NOT a non-billable activity for completion of the ACBH Screening Tool. (QRI #105)
- 93% of the claimed services provided were NOT a duplication of service. (QRI #106)
    - *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.*
- 94% of the claimed services provided were NOT supervision related. (QRI #107)
- 94% 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 #108)
- 72% of the progress notes were completed and signed within the "late note" timeline required by the MHP) (QRI #109)
    - *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.*
- 40% of the progress notes that were late indicated "late note" in the body of the progress note. (QRI #110)
- 92% 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 #111)
- 95% of the claimed services provided were NOT for a "No show" activity. (QRI#112)
- 100% of the claimed services provided were NOT for a non-therapeutic mandated reporting activity (mandated reported activities can be claimed if provided as a SMHS intervention with client or caregivers present.) (QRI#113)
- 95% 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#114)
- 95% of the claimed services provided were NOT for interpretation related activities. (QRI#115)

- 95% of the claimed services provided were NOT for a review of medical records without clinical justification and/or documentation of relevant content found. (QRI#116)
- 86% 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 #117)
- 76% of the progress notes indicated that interpreter services were used and the relationship to client was indicated, if applicable. (QRI #118)
- 95% of the progress notes documented that the service was provided within the scope of practice of the person delivering the service. (QRI #119)
  67% of Case management/Brokerage types (housing, economic, vocational, educational, medical needs, SUD, etc.) were compliant. (QRI #120)

➢ Chart Maintenance:

- 95% (19/20) of the charts noted the admission date correctly (EOD noted in chart should match InSyst). (QRI #121)
- 55% (11/20) 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 #122)
- 86% of the required signed releases of information were present. (QRI #123)
- The compliance rate for legibility in the charts was 100%. (QRI #124)
  - *This is a crucial item that if not met, may result in claims disallowances.*
  - *Five (5) areas of documents were reviewed for this quality item:*
    - *Assessments, Client Plans, Non-Clinical Forms, Progress Notes, and MD/NP Documents.*
- 99% of the signatures on the documents throughout all charts were legible (or printed name under signature or signature sheet was present). (QRI #125)
  - *This is a crucial item that if not met, may result in claims disallowances.*
- 100% of the charts contained service-related client correspondence in the client's preferred language. (QRI#126)
- 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#127)
- 100% (17/17) of the charts maintained a clinical record where documents were filed appropriately. (QRI #128)
- 90% of the pages across all charts identified the client (by name or InSyst #). (QRI #129)
- 25% (1/3) of the charts indicated the discharge/termination date correctly (matching InSyst), when applicable. (QRI #130)
- 99% of the documentation in the charts did not contain significant cut and paste activity. (QRI #131)
  - *This is a crucial item that if not met, may result in claims disallowances.*
  - *Five (5) areas of documents were reviewed for this quality item:*

        - *Assessments, Client Plans, Non-Clinical Forms, Progress Notes, and MD/NP Documents.*
    - 100% (20/20) of the charts contained documentation which only used county-designated acronyms and abbreviations. (QRI #132)

- Day Rehabilitation Services
    - QRIs #133 - #154 are all N/A because no charts providing Day Rehabilitative services were reviewed in this audit.

- Psychiatric Emergency Services / Crisis Stabilization Programs:
    - QRIs # 155 - #202 are all N/A because no charts providing Psychiatric Emergency or Crisis Stabilization services were reviewed in this audit.

- Site Compliance

  QRIs #203 – #205 are all N/A because this audit did not include site reviews

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 will also receive an individualized Audit Findings Report detailing the findings for their chart(s), needed follow-up, and an individualized Plan of Correction (POC) or Quality Improvement Plan (QIP) which lists all items to be addressed.

If you have any questions regarding the findings of this audit, you may contact:

Jeffery Sammis, PsyD.
Clinical Review Specialist Supervisor, ACBH QA Department
Jeffery.Sammis@acgov.org
(510) 567-8208

CLAIMS RECOUPMENT

The total recoupment amounts are estimates only based on InSyst service cost. Depending on the actual amount paid to the provider, the amounts indicated in this report may be adjusted by *ACBH Finance Department*. Actual cost programs must coordinate with *ACBH Finance Department* and their contract manager to determine accurate recoupment amounts.

APPEALS OF CLAIMS DISALLOWANCES

See appeal instructions below:

1. INFORMAL APPEAL TO ACBH

If a provider wishes to appeal any of the claims disallowances, they may do so by submitting a specific and detailed informal appeal letter in writing, along with supporting documentation, within thirty (30) calendar days of the date specified in the letter. Any appeals submitted beyond 30 days will not be reviewed and will be denied. Please email these documents to QA.Appeals@acgov.org.

Please note that providers are required to send any PHI using encrypted email. See instructions at the end of this letter. The expected ACBH response to the informal appeal is within 90 days of within receipt of the appeal.

2. DHCS APPEAL *(Only for non-County agencies disallowances of paid claims).*

Per CA Code of Regulations, Title 9, 1850.350: in lieu of, or after, the informal appeal to ACBH the provider may choose to appeal directly to the Department of Health Care Services in writing, along with supporting documentation, within 60 calendar days from the date of receipt of ACBH's written Audit Findings (or informal ACBH appeal findings) to the provider. Supporting documentation shall include, but not limited to: (1) Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos; (2) Clinical records supporting the existence of medical necessity if at issue; (3) A summary of reasons why the MHP should have approved the MHP payment authorization; and (4) A contact person(s) name, address and phone number. Submit your DHCS appeal by email to MHSD-Appeals@dhcs.ca.gov (no client private health information) or by mail to:

DHCS
Sergio Lopez, Chief
Quality Assurance Section
P.O. Box 997413, MS 2702
Sacramento, CA 95899-7413

3. ADDITIONAL APPEAL INSTRUCTIONS

If appealing claims disallowances to ACBH or DHCS, do not send recoupment payment at the time of appeal and do not submit a completed POC. The provider must inform the QA department if they plan to make an appeal to DHCS. The due date of the POC will be extended accordingly. Any requested POC will be due subsequent to the outcome of the Informal or Formal Appeal.

Only appeals of disallowed items will be accepted at the time of appeal. See POC section below for instructions on how to resolve quality (non-disallowed) results.

PLANS OF CORRECTION (POC) AND QUALITY IMPROVEMENT PLAN (QIP) REQUIREMENTS

If any QRIs have a corresponding auditor comment, as indicated in the provider's individual report, either a POC or QIP is required (but not both). See instructions POC or QIP instructions below.

PLANS OF CORRECTION (POC) INSTRUCTIONS

POCs are required for all providers who had claims disallowed in the audit. The POC must address the resolution of each Quality Review Item (QRI) and disallowed claims reasons indicated on the individual provider's Plan of Correction template.

Providers with claims disallowance rates of 50%, or higher, are required to participate in QA CQRT audit monitoring process. At 6 months, the CQRT process will be evaluated to determine if the process has improved the providers' documentation standards sufficiently to discontinue this process. Specific to this audit's results, there are no providers that meet this requirement.

The implementation of the POC must be applied to all of the agency programs that are contracted to provide Specialty Mental Health Services Medi-Cal.

Providers must submit the completed POC to the Quality Assurance Office no later than thirty (30) calendar days from the date of this report's issuance or the date of appeal resolution letter. ACBH QA audit lead will work with your agency to develop and approve the POC. Once approved by ACBH QA, the provider must implement the approved POC and provide evidence of implementation to ACBH QA within 90 days of the date of approval.

Submissions of POCs must be done electronically and in Word document format. Plans of Correction should not include PHI information in them. If you feel that your agency's POC needs to include PHI information, you must send the document via encrypted email. See instructions at the end of this report pertaining to encrypted submission of electronic files that contain PHI.

INFORMAL ACBH RESOLUTION OF QUALITY REVIEW ITEMS ON POC

If a provider disagrees with the findings for a QRI that did not result in a claims disallowance, they may explain their rationale in the POC and submit any supporting documents and other relevant evidence. Do not submit these with the claims appeal and if no claims disallowances are being appealed, providers must submit the POC within the required timeframe.

QUALITY IMPROVEMENT PLAN (QIP) INSTRUCTIONS.

QIPs are required for all providers who had non-compliant Quality Review Items (QRIs) but did not have any claims disallowed in the audit. The QIP must address the resolution of each QRI indicated on the individual provider's QIP template.

The implementation of the QIP must be applied to all of the agency programs that are contracted to provide Specialty Mental Health Services Medi-Cal.

Providers must submit the completed QIP to the Quality Assurance Office no later than thirty (30) calendar days from the date specified. The ACBH audit lead will work with your agency to develop and approve the QIP. Once approved by ACBH QA, the provider must implement the provisions of the QIP and retain evidence of implementation. Evidence of implementation must be provided to ACBH QA upon request.

Submissions of QIPs must be done electronically and in Word document format. QIPs should not include PHI information in them. If you feel that your agency's QIP needs to include PHI information, you must send the document via encrypted email. See instructions at the end of this letter pertaining to encrypted submission of electronic files that contain PHI.

INFORMAL ACBH RESOLUTION OF QUALITY ITEMS ON QIP

If a provider disagrees with the findings for a QRI, they may explain their rationale in the QIP and submit any supporting documents and other relevant evidence for ACBH review.

TRANSMITTING PROTECTED HEALTH INFORMATION (PHI)

Alameda County considers protecting the privacy of its Medi-Cal beneficiaries of utmost importance. Any communication of PHI must be done in accordance with current privacy and encryption standards. **DO NOT SUBMIT UNSECURED/UNENCRYPTED PHI, THIS IS CONSIDERED A PRIVACY BREACH.**

All providers must submit any documents that contain PHI by encrypted email to the audit lead indicated in this letter. Email correspondence between external entities must be encrypted to a minimum 128bit standard. For providers without email encryption or who want to use the county encrypted email service, please contact audit lead, Jeffery Sammis, PsyD. at Jeffery.Sammis@acgov.org. The ACBH audit lead will send you an encrypted email. You must use the web interface to send an encrypted reply.

For county email correspondence only: ACBH's internal email system is automatically encrypted and county employees using this system do not need to take additional security precautions.

REGULATIONS; STANDARDS; POLICIES

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

- CA Code of Regulations, Title 9
- DHCS Reasons for Recoupment For FY 2016-2017

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

LIST OF EXHIBITS

Exhibit 1: Claims Review Spreadsheet
Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for FY 2016-2017
Exhibit 3: Quality Review Spreadsheet
Exhibit 4: 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 Plan of Correction: 9

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 29, 35, 38, 40, 76, 78, 79, 106

2. Quality Improvement Plan Required: No

3. Claims Compliance: 86%

    a. Number of claims disallowed: 3

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 19a6b

4. Amount of claims (within the audit period) to be recouped: $579.74

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

Plan of Correction Needed: Yes

Provider P2 / Client C2

1. Quality Review Items Compliance: C2: 88%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 24, 25, 27, 28, 33, 34, 35, 37, 43, 45, 53, 76, 78, 79, 105, 109, 110, 122

2. Quality Improvement Plan Required: Yes

3. Claims Compliance: 100%

    a. Number of claims disallowed: 0

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

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

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

Plan of Correction Needed: No

Provider P3 / Client C3

1. Quality Review Items Compliance: C4: 96%

    a. Number of Quality Items to be addressed in the Plan of Correction: 6

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 23, 25, 34, 40, 53, 109

2. Quality Improvement Plan Required: Yes

3. Claims Compliance: 100%

    a. Number of claims disallowed: 0

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

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

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

6. Plan of Correction Needed: No

Provider P4 / Client C4

1. Quality Review Items Compliance: C4: 97%

    a. Number of Quality Items to be addressed in the Plan of Correction: 8

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 24, 64, 78, 94, 95, 109, 110, 122

2. Quality Improvement Plan Required: Yes

3. Claims Compliance: 100%

    a. Number of claims disallowed: 0

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

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

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

6. Plan of Correction Needed: No

Provider P5 / Client C5

1. Quality Review Items Compliance: C5: 84%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 13, 18, 33, 35, 37, 39, 50, 51, 52, 65, 81, 82, 89, 130

2. Quality Improvement Plan Required: No

3. Claims Compliance: 20%

    a. Number of claims disallowed: 4

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 5a, 5b, 10a, 10c

4. Amount of claims (within the audit period) to be recouped: $1,265.40

5. Amount of claims (planned services) outside the audit period to be recouped: $1,881.00

6. Total recoupment amount: $3,146.40

   Plan of Correction Needed: Yes

Provider P6 / Client C6

1. Quality Review Items Compliance: C6: 93%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 24, 25, 26, 28, 34, 37, 76, 109, 110, 122

2. Quality Improvement Plan Required: No

3. Claims Compliance: 94%%

    a. Number of claims disallowed: 1

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

4. Amount of claims (within the audit period) to be recouped: $120.42

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

Plan of Correction Needed: Yes

Provider P7 / Client C7

1. Quality Review Items Compliance: C7: 37%

    a. Number of Quality Items to be addressed in the Plan of Correction: 42

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 13, 75, 76, 77, 79, 81, 82, 83, 84, 85, 86, 87, 88, 93, 94, 95, 97, 98, 99, 100, 101, 102, 105, 106, 107, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 121, 78, 80, 122, 123, 130,

2. Quality Improvement Plan Required: No

3. Claims Compliance: 14%

    a. Number of claims disallowed: 12

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

4. Amount of claims (within the audit period) to be recouped: $1,985.55

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

Plan of Correction Needed: Yes

Provider P8 / Client C8

1. Quality Review Items Compliance: C8: 94%

    a. Number of Quality Items to be addressed in the Plan of Correction: 9

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 12, 24, 28, 37, 46, 65, 78, 82, 109

2. Quality Improvement Plan Required: No

3. Claims Compliance: 92%

    a. Number of claims disallowed: 1

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

4. Amount of claims (within the audit period) to be recouped: $331.20

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

Plan of Correction Needed: Yes

Provider P9 / Client C9

1. Quality Review Items Compliance: C9: 91%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 19, 26, 33, 34, 35, 37, 38, 42, 43, 44, 53, 76, 109, 110, 122, 123

2. Quality Improvement Plan Required: No

3. Claims Compliance: 86%

    a. Number of claims disallowed: 2

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

4. Amount of claims (within the audit period) to be recouped: $504.00

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

Plan of Correction Needed: Yes

Provider P10 / Client C10

1. Quality Review Items Compliance: C10: 78%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 18, 19, 20, 21, 23, 24, 25, 27, 28, 33, 34, 40, 41, 45, 46, 53, 63, 88, 107, 123, 129, 130

2. Quality Improvement Plan Required: No

3. Claims Compliance: 33%

    a. Number of claims disallowed: 10

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 1e, 2, 3, 4, 5e, 19a9

4. Amount of claims (within the audit period) to be recouped: $1,477.44

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

Plan of Correction Needed: Yes

<u>Provider P11 / Client C11</u>

1. Quality Review Items Compliance: C11: 98%

    a. Number of Quality Items to be addressed in the Plan of Correction: 6

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 44, 49, 53, 76, 102, 109

2. Quality Improvement Plan Required: No

3. Claims Compliance: 79%

    a. Number of claims disallowed: 3

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 18, 19a1, 19a6a

4. Amount of claims (within the audit period) to be recouped: $1,140.37

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

Plan of Correction Needed: Yes

Provider P12 / Client C12

1. Quality Review Items Compliance: C12: 91%

    a. Number of Quality Items to be addressed in the Plan of Correction: 15

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 13, 23, 27, 35, 38, 40, 41, 45, 72, 73, 76, 99, 109, 110, 122

2. Quality Improvement Plan Required: No

3. Claims Compliance: 82%

    a. Number of claims disallowed: 3

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 19a1, 13b

4. Amount of claims (within the audit period) to be recouped: $1,173.28

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

Plan of Correction Needed: Yes

Provider P13 / Client C13

1. Quality Review Items Compliance: C13: 88%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 18, 19, 20, 21, 24, 25, 33, 40, 41, 65, 66, 72, 109, 110

2. Quality Improvement Plan Required: No

3. Claims Compliance: 0%

    a. Number of claims disallowed: 9

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 1e, 2, 3, 4

4. Amount of claims (within the audit period) to be recouped: $2,845.56

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

Plan of Correction Needed: Yes

Provider P14 / Client C14

1. Quality Review Items Compliance: C14: 82%

    a. Number of Quality Items to be addressed in the Plan of Correction: 27

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 13, 18, 27, 33, 36, 38, 39, 40, 41, 44, 45, 46, 49, 50, 51, 52, 73, 76, 91, 97, 106, 109, 110, 111, 120, 125

2. Quality Improvement Plan Required: No

3. Claims Compliance: 36%

    a. Number of claims disallowed: 9

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 6e, 19a1, 19a8b, 19a15

4. Amount of claims (within the audit period) to be recouped: $4,398.85

5. Amount of claims (planned services) outside the audit period to be recouped: $70.10

6. Total amount recouped: $4,468.95

Plan of Correction Needed: Yes

Provider P15 / Client C15

1. Quality Review Items Compliance: C15: 91%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 11, 12, 13, 38, 40, 41, 51, 76, 81, 82, 84, 109, 110, 120, 122, 131

2. Quality Improvement Plan Required: No

3. Claims Compliance: 20%

    a. Number of claims disallowed: 12

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 10a, 10c, 19a1, 19a3, 19a20b

4. Amount of claims (within the audit period) to be recouped: $4,582.47

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

Plan of Correction Needed: Yes

Provider P16 / Client C16

1. Quality Review Items Compliance: C16: 85%

    a. Number of Quality Items to be addressed in the Plan of Correction: 21

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 24, 25, 26, 32, 35, 41, 51, 67, 68, 69, 70, 71, 76, 78, 84, 95, 107, 109, 110, 121, 122

2. Quality Improvement Plan Required: No

3. Claims Compliance: 57%

    a. Number of claims disallowed: 6

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 10c, 19a6a, 19a9, 19a20a

4. Amount of claims (within the audit period) to be recouped: $855.35

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

Plan of Correction Needed: Yes

Provider P17 / Client C17

1. Quality Review Items Compliance: C17: 98%

    a. Number of Quality Items to be addressed in the Plan of Correction: 9

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 40, 49, 76, 81, 82, 83, 106, 109, 110

2. Quality Improvement Plan Required: No

3. Claims Compliance: 85%

    a. Number of claims disallowed: 5

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 10a, 10c, 19a8b

4. Amount of claims (within the audit period) to be recouped: $1,319.04

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

Plan of Correction Needed: Yes

Provider P18 / Client C18

1. Quality Review Items Compliance: C18: 86%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 25, 27, 28, 30, 31, 34, 35, 36, 41, 45, 46, 63, 65, 101, 117, 129

2. Quality Improvement Plan Required: No

3. Claims Compliance: 90%

    a. Number of claims disallowed: 1

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 17a

4. Amount of claims (within the audit period) to be recouped: $145.20

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

Plan of Correction Needed: Yes

Provider P19 / Client C19

1. Quality Review Items Compliance: C19: 61%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 13, 18, 19, 20, 21, 23, 24, 25, 27, 28, 32, 33, 34, 40, 41, 42, 44, 45, 46, 47, 48, 53, 63, 65, 75, 76, 77, 78, 80, 82, 83, 84, 85, 86, 87, 88, 91, 92, 93, 94, 95, 96, 97, 99, 100, 101, 102, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 123, 129

2. Quality Improvement Plan Required: No

3. Claims Compliance: 0%

    a. Number of claims disallowed: 6

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 1e, 2, 3, 4, 6e, 6f, 6g, 9, 10b

4. Amount of claims (within the audit period) to be recouped: $547.65

5. Amount of claims (planned services) outside the audit period to be recouped: $1,932.00

6. Total amount to be recouped: $2,479.65

Plan of Correction Needed: Yes

Provider P20 / Client C20

1. Quality Review Items Compliance: C20: 90%

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

    b. The Quality non-compliance reasons (Exhibit 4: Quality Review Key) to be addressed in the Plan of Correction: Quality Review Items: 18, 19, 20, 21, 24, 25, 34, 41, 51, 76, 88, 95, 96, 106, 120, 122

2. Quality Improvement Plan Required: No

3. Claims Compliance: 0%

    a. Number of claims disallowed: 15

    b. Reasons for DHCS claims disallowances (Exhibit 2: DHCS Reasons for Recoupment with ACBH Claims Comments for System of Care Audit Report): Item Numbers: 1f, 2, 3, 4, 19a1, 19a6a, 19a8b, 19a20c

4. Amount of claims (within the audit period) to be recouped: $3,393.61

5. Amount of claims (planned services) outside the audit period to be recouped: $10,265.40

6. Total amount to be recouped: $13,659.01

Plan of Correction Needed: Yes