Confidential QA Report
COSD DMC-ODS Plan
Substance Use Disorder Services
Fiscal Year 25-26

Chart Review Information

Agency/Legal Entity Name:	
Program Name:	
Total Services for Review:	0

Review Start Date:	
Review End Date:	
Billing Review Period Start:	
Billing Review Period End:	

Records to be Reviewed

Tab	SmartCare Client ID#	Insurance	# of Services to be Reviewed	Reviewer	Admit Date	Discharge Date
Client 1	N/A					
Client 2	N/A					
Client 3	N/A					
Client 4	N/A					
Client 5	N/A					
Client 6	N/A					
Client 7	N/A					
Client 8	N/A					
Client 9	N/A					
Client 10	N/A					
Client 11	N/A					
Client 12	N/A					
Client 13	N/A					
Client 14	N/A					
Client 15	N/A					
Client 16	N/A					
Client 17	N/A					
Client 18	N/A					
Client 19	N/A					
Client 20	N/A					

* Use "N/A" in the SmartCare Client ID# field for any Client rows that will not be used. Do not leave SmartCare Client ID# cells blank.

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Chart Review Results

Agency/Legal Entity Name	0
Program Name	0
Total Services for Review	0

# of Disallowed Services	0
Disallowance %	0%
Disallowed Services Cost	$0.00

Review Start Date:	
Review End Date:	
Billing Review Period Start:	
Billing Review Period End:	

# of Compliant Charts	0
Compliant Charts %	#DIV/0!

Overall Compliance %	#DIV/0!
QIP Required?	

Overall Result: Percentage represents number of yes response(s) divided by the total number of yes and no response(s). N/A responses are not included.

Service Disallowance rate is the number of disallowed services divided by the total number of services reviewed. The disallowance rate does not include non-billable services or services that can be edited/corrected/claimed. Recouped services are based on the DHCS Reasons for Recoupment and can be viewed on the DHCS website.

Disallowance Cost in Dollars: The dollar amount for all claimed services that were disallowed during the review period.

 # Charts in Compliance: Counts all charts with an compliance rate of 90% or higher.

Quality Improvement Plan (QIP) Requirements

Refer to the comments section at the end of each item for QA Reviewer feedback.

1. A QIP is required if the Overall Result is below 90% or if disallowance rate exceeds 5%. The QIP shall include the Services Change Summary. A QIP may also be requested at the discretion of the QA Specialist for any significant deficiencies/trends identified in the review.

2. If the Overall Result is below 80%, the QA Specialist conducting your review will follow up three months after QIP approval to collect evidence demonstrating that the QIP has assisted in improved compliance.

3. Any services listed on the Services Change Summary shall be corrected on the Services Change Summary and submitted to QA within 14 calendar days of receipt of QAPR. A copy of the Billing Unit Payment Recovery Form sent to the BHS Billing Unit shall be submitted to QA along with the Services Change Summary, if applicable.

4. Quality Improvement Plans are due to the QA Unit within 14 calendar days of receipt of the final QAPR report.

Prior year QAPR Results and Quality Improvement Plan Comments:

1.

2.

3.

4.

5.

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Strengths and Commendable Efforts

Quality Improvement Recommendations

Total Corrected Services and Disallowances by Client

Client	Services Reviewed	Services Corrected	Services Disallowed	Amount Disallowed
Client_1				$ -
Client_2				$ -
Client_3				$ -
Client_4				$ -
Client_5				$ -
Client_6				$ -
Client_7				$ -
Client_8				$ -
Client_9				$ -
Client_10				$ -
Client_11				$ -
Client_12				$ -

Findings by Category, all Clients

Category	Items Scored	Total Findings
Policy & Procedures (P&P)	0	0
Intake	0	0
Screening/Assessment	0	0
Diagnosis/Problem List	0	0
Participant List Documentation	0	0
Progress Notes	0	0
Care Coordination Services	0	0
Billing	0	0
Discharge Documentation	0	0
Naltrexone Services	0	0
Recovery Services	0	0
Peer Support Services	0	0

Client_13				$	-
Client_14				$	-
Client_15				$	-
Client_16				$	-
Client_17				$	-
Client_18				$	-
Client_19				$	-
Client_20				$	-
Totals	**0**	**0**	**0**	**$**	**-**

Perinatal Services	0	0
Withdrawal Management Services/AWM	0	0

	Item	Met %
	INTAKE	**N/A**
1.1	Are all of the following informing materials completed and included in the medical record? - Consent to treatment/Admission Agreement, signed and dated by the member - Member's Rights, signed and dated by the member - Evidence that Integrated Member Handbook/Fair Hearing Rights information has been provided to member. - Financial Agreement form - Notice of Privacy Practices/ HIPAA Confidentiality - Releases of Information compliant with 42 Code of Federal Regulations (CFR) - Health Questionnaire - TB screening - Risk assessment - If member was admitted with medications, documented immediately on the Centrally Stored Medication and Destruction Record (Residential/Withdrawal Management/AWM) - Advance Directives Title IX requirements; Title 42, Code of Federal Regulations (CFR), Section 438.10	**N/A**
1.2	If telehealth or telephone services are provided, is there documented consent (written or verbal) specific to the provision of telehealth services prior to initial delivery of services? Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services and must explain the following to member: • The member has a right to access covered services in person. • Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access Medi-Cal covered services in the future. • Non-medical transportation benefits are available for in-person visits. • Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable. (BHIN 23-018)	**N/A**
1.3	Is all of the following demographic and identifying information included in the medical record: - Member identifier (name, number, etc.) - Date of birth - Gender identity - Race/ethnic backgrounds - Permanant Address - Documentation of member living arrangements while attending the program - Telephone number - Next of kin or emergency contact information (including phone number and consent of member to notify contact) (BHIN 25-003)	**N/A**
1.4	For members whose primary language is not English, is there evidence of informing materials provided to member in their primary/preferred language? Do progress notes document the language of service provided (if other than English)?	**N/A**
1.5	For member with identified disabilities, is there documentation that services were provided in alternate formats and/or accommodation of disability?	**N/A**

1.6	Does chart contain documentation of random drug testing/Body Specimen Screening. When positive screening occurs, documentation supports counselor has addressed with member and additional services as needed (i.e. assess for higher level of care, risk assessment update, relapse plan update). Title 22, California Code of Regulations (CCR), Section 51341.1	**N/A**
1.7	Physician has reviewed documentation of the most recent physical exam (within 12 months prior to admission to treatment) within 30 calendar days of admission to treatment. If provider is unable to obtain documentation of the most recent physical exam, provider must describe efforts made to obtain such documentation in the chart. As an alternative to complying with the above, a pysician, registered nurse practitioner, or a physician assistant may perform a physical exam within 30 days of admission to treatment.	**N/A**
	SCREENING/ASSESSMENT	**N/A**
2.1	Has completed a screening (BQuIP for Adults or other screening tools for youth/young adults)? 1. Is actual level of care the same as the indicated Level of Care (LOC), or is the change sufficiently justified? If there is a discrepancy, is there a quality of care concern?	**N/A**
2.2	Does the ASAM document the following: 1. Is actual level of care the same as the indicated Level of Care (LOC), or is the change sufficiently justified? If there is a discrepancy, is there a quality of care concern? 2. Do member-specific facts cited in each dimension support the severity rating chosen for that dimension? 3. Is the indicated level of care supported by the severity ratings in each of the dimensions? WM programs do not require an assessment if a screening was completed.	**N/A**
2.3	Residential Programs Only: Is there a multidimensional LOC assessment and corresponding authorization within 72 hours of admission with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor that includes a typed or legibly printed name, signature of the service provider and date of signature? (BHIN 23-068)	**N/A**
2.4	Was member screened for priority population status (pregnant person using IV substances, pregnant person using other non-IV substances, person using IV substances)? SUBG	**N/A**
2.5	If the multidimensional assessment is completed by AOD Counselor, does documentation (ie: progress note or co-signed assessment document) support a face to face or telehealth meeting between AOD Counselor and LPHA to review assessment and intake information to determine medical necessity?	**N/A**
	DIAGNOSIS/PROBLEM LIST	**N/A**
3.1	Does the clinical record contain at least one diagnosis from the Diagnostic and Statistical Manual (DSM 5) for Substance-Related and Addictive Disorder, with the exception of Tobacco-related Disorders and Non-Substance-Related Disorders and does documentation support diagnosis (within scope of practice) and need for DMC-ODS services according to BHIN 24-001? If no, identify the services in the Progress Notes Summary. BHIN 22-063, Enclosure 3 - Reasons for Recoupment	**N/A**
3.2	Has the Medical Director or LPHA typed or legibly printed their name, signed and dated the diagnosis documentation? (BHIN 23-068)	**N/A**
3.3	If applicable, does the problem list reflect the current member needs (i.e. diagnosis documents and their updates)? Are the updates made within a reasonable time and in accordance with generally accepted standards of practice?	**N/A**
3.4	If applicable, does the problem list include all required elements? - Name and title of each provider that identified, added or removed items from the problem list. - The date the items were identified, added or removed. (BHIN 23-068)	**N/A**
3.5	If tobacco use is identified in the assessment and included on problem list, was there evidence of treatment or a referral for tobacco use disorder offered?	**N/A**
	PARTICIPANT LIST DOCUMENTATION	**N/A**
4.1	Are all groups limited to no less than 2 and no more than 12 participants) with exception for patient education groups in residential treatment which may be more than 12 participants)? For every group counseling session, are the following included: - The date, topic, start/end time, type of service, location of the counseling session? - A typed or legibly printed name, signature of the service provider and date of signature? BHIN 23-068; (Title 22, California Code of Regulations (CCR) Section 51341.1)	**N/A**
	PROGRESS NOTES	**N/A**

5.1	Were the majority of progress notes finalized within 3 business days (date of service is day 0) with the exception of progress notes for crisis services, which shall be completed within 24 hours? BHIN 22-019	**N/A**
5.2	Do all progress notes include the typed or legibly printed name of the provider and the date of signature? (For outpatient programs only the progress note should be signed by the person providing the service include the legible name of the provider, the date of signature?) BHIN 23-068	**N/A**
5.3	Do the progress notes include the following elements: a sufficient description of SUD intervention(s) provided, EBP used and next steps to be taken by provider (i.e., plan)? (BHIN 23-068)	**N/A**
5.4	Have all risk and safety issues in the member record been addressed and for member with identified risks, do progress notes document ongoing assessment, clinical monitoring, and intervention(s) that relate to the level of risk, when appropriate?	**N/A**
5.5	Based on the documentation as a whole, is there evidence that treatment is high quality, person centered, culturally responsive and aligned with member needs?	**N/A**
	CARE COORDINATION SERVICES	**N/A**
6.1	Do services identify activities that provide coordination of SUD care, mental health care, and medical care, in addition to supporting the member with linkages to services and supports designed to restore the member to their best possible functional level? (BHIN 23-068)	**N/A**
6.2	If there is an identified need for MAT services, is there evidence that the provider has either provided MAT directly or provided the member with a referral and warm hand-off to MAT services ensuring that the member has followed through with referral?	**N/A**
6.3	For members with physical health needs related to their mental health treatment, do progress notes document that physical health care is integrated into treatment through education, resources, referrals, symptom management and/or care coordination with physical healthcare providers?	**N/A**
	BILLING	**N/A**
7.1	Is there any evidence of fraud, waste, or abuse? If yes, identify the claims in the Services Addendum.	**N/A**
7.2	Were any services provided while the member was in a Medi-Cal lock-out place of service (e.g., psych hospitalization, Institution for Mental Disease (IMD) juvenile hall*, jail)? If yes, identify the services in the Services Addendum. CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.3601840.374; 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, Code of Federal Regulations, title 42, sections 435.1009 – 435.1010; CCR, title 22, section 50273(a)(5-8), (c)(1, 5); title 22, section 51458.1(a)(8).	**N/A**
7.3	Is there documentation of a valid allowable service for every claim billed within the review period? If no, identify the claims in the Services Addendum. CCR, title 9, section 1840.112(b)(3); BHIN 22-019; MHP Contract, Exhibit E, Attachment 1); CCR, title 22, section 51458.1(a)(3)(7).	**N/A**
7.4	Does the date of service listed on the progress notes match the date of service listed on all claims? If no, identify the claims in the Services Addendum. **Recoupment is limited to examples where the program is unable to provide other documented evidence that the progress note with the “mismatched” date actually corresponds to the claim in question, and/or was due to a clerical error.** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).	**N/A**
7.5	For all progress notes, did the service that was claimed (procedure code) match the service documented in the progress note? If no, identify the claims in the Services Addendum. (For valid medical claims, appropriate ICD CM dx codes, as well as HCPC/CPT codes, must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note.) **Results in recoupment only when there is an overbilling** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).	**N/A**

7.6	Do all units of time for services match the amount of time documented in the progress note? If no, identify the claims in the Services Addendum. **Recoupment is limited to mismatches that result in over billing.** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c); MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).	**N/A**
7.7	Do all progress notes include required elements (date of service, service type, person contacted, location of service, contact type, evidence-based practice (EBP), appointment type)?	**N/A**
7.8	Do individual and/or group progress notes with multiple providers clearly identify the number of providers and the specific involvement and interventions of each provider? If no, identify the claims in the Services Addendum. CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5; CCR, title 22, section 51458.1(a)(3).	**N/A**
7.9	Are all documented services within the scope of practice of the provider? If no, identify the claims in the Services Addendum.	**N/A**
7.10.	Do group progress notes identify the total number of participants in the service activity? If no, identify the claims in the Services Addendum. CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5; CCR, title 22, section 51458.1(a)(3).	**N/A**
7.11	Were all services billable according to Title 9, (meaning that no services claimed that were solely academic, vocational, recreation, socialization, transportation, clerical or payee related)? If no, identify the claims in the Services Addendum.	**N/A**
	DISCHARGE DOCUMENTATION	**N/A**
8.1	Discharge Plan (for planned discharge) includes: - Description of member triggers - A plan to avoid relapse when confronted with these triggers - A support plan	**N/A**
8.2	Discharge summary includes all of the following: - duration of member's treatment as determined by the dates of admission to and discharge from treatment - the reason for discharge - a narrative summary of the treatment episode and a continuing recovery plan that includes individual strategies to assist the member in sustaining long-term recovery. - the member's prognosis, - and when applicable (residential) member was provided with NOABD within proper timelines and NOABD is documented in SmartCare (Progress Note) or logged in another location; all NOABD information is documented.	**N/A**
8.3	Is there evidence of discharge planning and warm hand-off, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and/or referrals to primary or specialty medical providers, as clinically indicated for the member?	**N/A**
	NALTREXONE SERVICES	**N/A**
9.1	Does the member have a confirmed, documented history of opiate and/or alcohol addiction?	**N/A**
9.2	Is the member at least 18 years of age, opiate free and not pregnant?	**N/A**
9.3	Naltrexone services: Are there at least two face-to-face counseling sessions with a therapist or counselor every 30-day period?	**N/A**
	RECOVERY SERVICES	**N/A**
10.1	Is there evidence that the member has been provided behavioral health resources?	**N/A**
10.2	Do services emphasize the member central role in managing their health, help the member identify effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to member?	**N/A**
	PEER SUPPORT SERVICES	**N/A**
11.1	Do services provide evidence of helping to prevent relapse, empowering the member through strength-based coaching, supporting linkages to community resources, and educating the member and family about the member's condition and the process of recovery? (BHIN 22-026)	**N/A**
11.2	Are required elements for a relevant care plan found within the member record (i.e.: progress note)? BHIN 23-068 - Care Planning	**N/A**
	PERINATAL SERVICES	**N/A**

12.1	Do services rendered address treatment and recovery issues specific to pregnant and postpartum women such as relationships, sexual and physical abuse, and development of parenting skills? (Title 22, Section 51341.1)	**N/A**
12.2	Does the medical documentation substantiate the member's pregnancy and is the last day of pregnancy documented in the member's record? (Title 22, Section 51341.1.) (BHIN 23-068/Perinatal Practice Guidelines-DHCS)	**N/A**
12.3	Are required elements for a relevant care plan found within the member record (ie: progress note)? BHIN 23-068 - Care Planning	**N/A**
12.4	If member has not had a physical exam in the last 12 months or physical exam results are not present, obtaining a physical exam is present on the Perinatal Plan of Care? (Title 22, Section 51341.1.) (BHIN 23-068/Perinatal Practice Guidelines-DHCS)	**N/A**
12.5	Pregnancy/physical exam: Evidence of timelines met for physical examination requirements for pregnant/peri members.	**N/A**
12.6	Required treatment issues: Evidence required areas/issues included in treatment (see PPG, includes parenting skills); review of problem lists, referrals, Sign in sheets, Program scheduled (Title 22, Section 51341.1.) (Perinatal Practice Guidelines-DHCS)	**N/A**
	WITHDRAWAL MANAGEMENT SERVICES/AWM	**N/A**
13.1	If prescribed and/or OTC medications were self-administered during the episode, monitoring (including times taken) are logged.	**N/A**
13.2	WM observation log is completed as required.	**N/A**
13.3	There is documentation of development of referral plan. (MHSUDS INFORMATION NOTICE NO: 15-048)	**N/A**

	Policy & Procedures			
	Program has written P&Ps and is following written P&Ps for the following:			**Comments:**
	A: Program Quality Assurance/Quality Improvement/Quality Management:			
P&P1	**- Internal QI/QM & Peer reviews**			
P&P2	**- Program Integrity/Paid Claims Verification (including how to report, manage and resolve FWA)**			
	B: Covered Services:			
P&P3	**- Early intervention**			
P&P4	**- OS 1.0 /IOS 2.1/AWM**			
P&P5	**- Residential 3.1 & 3.5 (including authorization of services)**			
P&P6	**- Withdrawal Management 3.2**			
P&P7	**- Recovery Services**			
P&P8	**- Teen Recovery Services**			
P&P9	**- MAT**			
P&P10	**- Care Coordination**			
	C: Client Rights:			
P&P11	**- Access to services/addressing barriers**			
P&P12	**- Providing translation services to members whose preferred language is other than English; Limited English Proficiency posters in all 9 languages are posted)**			
P&P13	**- Grievance & Appeal information is available to members in all threshold languages and posted**			
P&P14	**- Forms/self-addressed and postage paid envelopes for G&A are easily accessible to members without need for asking**			
P&P15	**- Notice of Privacy Practices are posted in an area that is visible and accessible to all members**			
P&P16	**- Program has their Open Database Notification to Clients posted in an area that is visible and accessible to all members**			
P&P17	**- Program rules, expectation and regulations posted or provided**			
P&P18	**D: Assessment**			
P&P19	**E: Monitoring/Supervision of EBP**			
P&P20	**F: Medication Monitoring (storage, self-administration)**			
P&P21	**G: Medical Director's P&P**			
P&P22	**H: Telehealth**			
P&P23	**I: Relapse Plan**			
P&P24	**J: Admission/Re-admission criteria (medical necessity, DSM diagnosis, use of alcohol/drug of abuse, physical health status, social & psychological problems, ASAM LOC determination, and referral process for members not meeting admission criteria)**			
P&P25	**K: Perinatal (specialty populations) care plan requirements & transportation**			

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Services Change Summary

Agency/Legal Entity	0
Program Name	0
Total Services for Review	0

Review Start Date:	1/0/00
Review End Date:	1/0/00
Billing Review Period Start:	1/0/00
Billing Review Period End:	1/0/00

After adding/updating data in the Chart Review Info tab or the individual Client tabs, click on Data > Refresh All to refresh these tables.

Corrective Action Type (For Program Use)

Place an "X" in the column below to indicate the corrective action for each service(s) and the date action was completed. Final Action Date: The date in which the final corrective action step has been completed. Program is required to submit a "final" Services Change Summary to the QA Specialist when all services have had final adjudication.

Services to be Corrected

SmartCare Client ID#	Staff Initials	Procedure Code	Procedure Name	Service Date	Reason for Correction	Comments	Client #	Amount Claimed	Self Correction Resolve Date	"My Reported Error" Correction Date Submitted	"My Reported Error" Correction Date Resolved
Grand Total											

Corrective Action Type (For Program Use)

Place an "X" in the column below to indicate the corrective action for each service(s) and the date action was completed. Final Action Date: The date in which the final corrective action step has been completed. Program is required to submit a "final" Billing Summary Form to the QA Specialist when all services have had final adjudication.

Services to be Disallowed

SmartCare Client ID#	Staff Initials	Procedure Code	Procedure Name	Service Date	Disallowed Requirement #	Comments	Client #	Amount Claimed	Self Correction Resolve Date	"My Reported Error" Correction Date Submitted	"My Reported Error" Correction Date Resolved
Grand Total											

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Agency/Legal Entity Name	Program Name	Billing Review Period		
		1/0/1900	to	1/0/1900

Client #	SmartCare Client ID#	LOC at Start of Review Period	LOC at End of Review Period	Insurance	Reviewer
1	N/A			0	0

Total Disallowed:
$0.00

REQ #	INTAKE	RESULT	FINDING	COMMENTS	Services Addendum: Service #	Staff Initials	Procedure Code	Procedure Name	Service Date	$ Claimed	Reason for Correction	Disallowed Requirement #	Comments
1.1	Are all of the following informing materials completed and included in the medical record? - Consent to treatment/Admission Agreement, signed and dated by the member - Member's Rights, signed and dated by the member - Evidence that Integrated Member Handbook/Fair Hearing Rights information has been provided to member. - Financial Agreement form - Notice of Privacy Practices/ HIPAA Confidentiality - Releases of Information compliant with 42 Code of Federal Regulations (CFR) - Health Questionnaire - TB screening - Risk assessment - If member was admitted with medications, documented immediately on the Centrally Stored Medication and Destruction Record (Residential/Withdrawal Management/AWM) - Advance Directives Title IX requirements: Title 42, Code of Federal Regulations (CFR), Section 438.10												
1.2	If telehealth or telephone services are provided, is there documented consent (written or verbal) specific to the provision of telehealth services prior to initial delivery of services? Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services and must explain the following to member: • The member has a right to access covered services in person. • Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access Medi-Cal covered services in the future. • Non-medical transportation benefits are available for in-person visits. • Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.												
1.3	Is all of the following demographic and identifying information included in the medical record: - Member identifier (name, number, etc.) - Date of birth - Gender identity - Race/ethnic backgrounds - Permanant Address - Documentation of member living arrangements while attending the program - Telephone number - Next of kin or emergency contact information (including phone number and consent of member to notify contact)												
1.4	For members whose primary language is not English, is there evidence of informing materials provided to member in their primary/preferred language? Do progress notes document the language of service provided (if other than English)?												
1.5	For member with identified disabilities, is there documentation that services were provided in alternate formats and/or accommodation of disability?												
1.6	Does chart contain documentation of random drug testing/Body Specimen Screening. When positive screening occurs, documentation supports counselor has addressed with member and additional services as needed (i.e. assess for higher level of care, risk assessment update, relapse plan update). Title 22, California Code of Regulations (CCR), Section 51341.1												

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Agency/Legal Entity Name	Program Name	Billing Review Period		
		1/0/1900	to	1/0/1900

Client #	SmartCare Client ID#	LOC at Start of Review Period	LOC at End of Review Period	Insurance	Reviewer

REQ #	SCREENING/ASSESSMENT	RESULT	FINDING	COMMENTS
1.7	Physician has reviewed documentation of the most recent physical exam (within 12 months prior to admission to treatment) within 30 calendar days of admission to treatment. If provider is unable to obtain documentation of the most recent physical exam, provider must describe efforts made to obtain such documentation in the chart. As an alternative to complying with the above, a pysician, registered nurse practitioner, or a physician assistant may perform a physical exam within 30 days of admission to treatment.			
2.1	Has completed a screening (BQuIP for Adults or other screening tools for youth/young adults)? 1. Is actual level of care the same as the indicated Level of Care (LOC), or is the change sufficiently justified? If there is a discrepancy, is there a quality of care concern?			
2.2	Does the ASAM document the following: 1. Is actual level of care the same as the indicated Level of Care (LOC), or is the change sufficiently justified? If there is a discrepancy, is there a quality of care concern? 2. Do member-specific facts cited in each dimension support the severity rating chosen for that dimension? 3. Is the indicated level of care supported by the severity ratings in each of the dimensions? WM programs do not require an assessment if a screening was completed.			
2.3	Residential Programs Only: Is there a multidimensional LOC assessment and corresponding authorization within 72 hours of admission with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor that includes a typed or legibly printed name, signature of the service provider and date of signature? (BHIN 23-068)			
2.4	Was member screened for priority population status (pregnant person using IV substances, pregnant person using other non-IV substances, person using IV substances)? SUBG			
2.5	If the multidimensional assessment is completed by AOD Counselor, does documentation (ie: progress note or co-signed assessment document) support a face to face or telehealth meeting between AOD Counselor and LPHA to review assessment and intake information to determine medical necessity?			

REQ #	DIAGNOSIS/PROBLEM LIST	RESULT	FINDING	COMMENTS
3.1	Does the clinical record contain at least one diagnosis from the Diagnostic and Statistical Manual (DSM 5) for Substance-Related and Addictive Disorder, with the exception of Tobacco-related Disorders and Non-Substance-Related Disorders and does documentation support diagnosis (within scope of practice) and need for DMC-ODS services according to BHIN 24-001? If no, identify the services in the Progress Notes Summary. BHIN 22-063, Enclosure 3 - Reasons for Recoupment			

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3.2	Has the Medical Director or LPHA typed or legibly printed their name, signed and dated the diagnosis documentation? (BHIN 23-068)												
3.3	If applicable, does the problem list reflect the current member needs (i.e. diagnosis documents and their updates)? Are the updates made within a reasonable time and in accordance with generally accepted standards of practice?												
3.4	If applicable, does the problem list include all required elements? - Name and title of each provider that identified, added or removed items from the problem list. - The date the items were identified, added or removed. (BHIN 23-068)												
3.5	If tobacco use is identified in the assessment and included on problem list, was there evidence of treatment or a referral for tobacco use disorder offered?												

REQ #	PARTICIPANT LIST DOCUMENTATION	RESULT	FINDING	COMMENTS
4.1	Are all groups limited to no less than 2 and no more than 12 participants) with exception for patient education groups in residential treatment which may be more than 12 participants)? For every group counseling session, are the following included: - The date, topic, start/end time, type of service, location of the counseling session? - A typed or legibly printed name, signature of the service provider and date of signature? BHIN 23-068; (Title 22, California Code of Regulations (CCR) Section 51341.1)			

REQ #	PROGRESS NOTES	RESULT	FINDING	COMMENTS
5.1	Were the majority of progress notes finalized within 3 business days (date of service is day 0) with the exception of progress notes for crisis services, which shall be completed within 24 hours? BHIN 22-019			
5.2	Do all progress notes include the typed or legibly printed name of the provider and the date of signature? (For outpatient programs only the progress note should be signed by the person providing the service include the legible name of the provider, the date of signature?) BHIN 23-068			

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5.3	Do the progress notes include the following elements: a sufficient description of SUD intervention(s) provided, EBP used and next steps to be taken by provider (i.e., plan)? (BHIN 23-068)			
5.4	Have all risk and safety issues in the member record been addressed and for member with identified risks, do progress notes document ongoing assessment, clinical monitoring, and intervention(s) that relate to the level of risk, when appropriate? (BHIN 23-068)			
5.5	Based on the documentation as a whole, is there evidence that treatment is high quality, person centered, culturally responsive and aligned with member needs?			

REQ #	CARE COORDINATION SERVICES	RESULT	FINDING	COMMENTS
6.1	Do services identify activities that provide coordination of SUD care, mental health care, and medical care, in addition to supporting the member with linkages to services and supports designed to restore the member to their best possible functional level? (BHIN 23-068)			
6.2	If there is an identified need for MAT services, is there evidence that the provider has either provided MAT directly or provided the member with a referral and warm hand-off to MAT services ensuring that the member has followed through with referral? (BHIN 23-054)			
6.3	For members with physical health needs related to their mental health treatment, do progress notes document that physical health care is integrated into treatment through education, resources, referrals, symptom management and/or care coordination with physical healthcare providers?			

REQ #	BILLING	RESULT	FINDING	COMMENTS
7.1	Is there any evidence of fraud, waste, or abuse? If yes, identify the claims in the Services Addendum.			
7.2	Were any services provided while the member was in a Medi-Cal lock-out place of service (e.g., psych hospitalization, Institution for Mental Disease (IMD) juvenile hall*, jail)? If yes, identify the services in the Services Addendum. CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.3601840.374; 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, Code of Federal Regulations, title 42, sections 435.1009 – 435.1010; CCR, title 22, section 50273(a)(5-8), (c)(1, 5); title 22, section 51458.1(a)(8).			

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7.3	Is there documentation of a valid allowable service for every claim billed within the review period? If no, identify the claims in the Services Addendum. CCR, title 9, section 1840.112(b)(3); BHIN 22-019; MHP Contract, Exhibit E, Attachment 1); CCR, title 22, section 51458.1(a)(3)(7).						
7.4	Does the date of service listed on the progress notes match the date of service listed on all claims? If no, identify the claims in the Services Addendum. **Recoupment is limited to examples where the program is unable to provide other documented evidence that the progress note with the "mismatched" date actually corresponds to the claim in question, and/or was due to a clerical error.** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).						
7.5	For all progress notes, did the service that was claimed (procedure code) match the service documented in the progress note? If no, identify the claims in the Services Addendum. (For valid medical claims, appropriate ICD CM dx codes, as well as HCPC/CPT codes, must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note.) **Results in recoupment only when there is an overbilling** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).						
7.6	Do all units of time for services match the amount of time documented in the progress note? If no, identify the claims in the Services Addendum. **Recoupment is limited to mismatches that result in over billing.** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c); MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).						
7.7	Do all progress notes include required elements (date of service, service type, person contacted, location of service, contact type, evidence-based practice (EBP), appointment type)?						
7.8	Do individual and/or group progress notes with multiple providers clearly identify the number of providers and the specific involvement and interventions of each provider? If no, identify the claims in the Services Addendum. CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5; CCR, title 22, section 51458.1(a)(3).						
7.9	Are all documented services within the scope of practice of the provider? If no, identify the claims in the Services Addendum. CCR, title 9, section 1840.314(d); BHIN 22-019						
7.10.	Do group progress notes identify the total number of participants in the service activity? If no, identify the claims in the Services Addendum. CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5; CCR, title 22, section 51458.1(a)(3).						

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7.11	Were all services billable according to Title 9, (meaning that no services claimed that were solely academic, vocational, recreation, socialization, transportation, clerical or payee related)? If no, identify the claims in the Services Addendum. CCR, title 9, sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), 1840.312(a-f) CCR, title 22, section 51458.1(a)(7).			

REQ #	DISCHARGE DOCUMENTATION	RESULT	FINDING	COMMENTS
8.1	Discharge Plan (for planned discharge) includes: - Description of member triggers - A plan to avoid relapse when confronted with these triggers - A support plan			
8.2	Discharge summary includes all of the following: - duration of member's treatment as determined by the dates of admission to and discharge from treatment - the reason for discharge - a narrative summary of the treatment episode and a continuing recovery plan that includes individual strategies to assist the member in sustaining long-term recovery. - the member's prognosis, - and when applicable (residential) member was provided with NOABD within proper timelines and NOABD is documented in SmartCare (Progress Note) or logged in another location; all NOABD information is documented.			
8.3	Is there evidence of discharge planning and warm hand-off, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and/or referrals to primary or specialty medical providers, as clinically indicated for the member?			

REQ #	NALTREXONE SERVICES	RESULT	FINDING	COMMENTS
9.1	Does the member have a confirmed, documented history of opiate and/or alcohol addiction?			
9.2	Is the member at least 18 years of age, opiate free and not pregnant?			
9.3	Naltrexone services: Are there at least two face-to-face counseling sessions with a therapist or counselor every 30-day period? (Title 22, Section 51341.1)			

REQ #	RECOVERY SERVICES	RESULT	FINDING	COMMENTS
10.1	Is there evidence that the member has been provided behavioral health resources?			

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10.2	Do services emphasize the member central role in managing their health, help the member identify effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to member? (BHIN 21-020)			

REQ #	PEER SUPPORT SERVICES	RESULT	FINDING	COMMENTS
11.1	Do services provide evidence of helping to prevent relapse, empowering the member through strength-based coaching, supporting linkages to community resources, and educating the member and family about the member's condition and the process of recovery? (BHIN 22-026)			
11.2	Are required elements for a relevant care plan found within the member record (i.e.: progress note)? BHIN 23-068 - Care Planning			

REQ #	PERINATAL SERVICES	RESULT	FINDING	COMMENTS
12.1	Do services rendered address treatment and recovery issues specific to pregnant and postpartum women such as relationships, sexual and physical abuse, and development of parenting skills? (Title 22, Section 51341.1)			
12.2	Does the medical documentation substantiate the member's pregnancy and is the last day of pregnancy documented in the member's record? (Title 22, Section 51341.1.) (BHIN 23-068/Perinatal Practice Guidelines-DHCS)			
12.3	Are required elements for a relevant care plan found within the member record (ie: progress note)? BHIN 23-068 - Care Planning			
12.4	If member has not had a physical exam in the last 12 months or physical exam results are not present, obtaining a physical exam is present on the Perinatal Plan of Care? (Title 22, Section 51341.1.) (BHIN 23-068/Perinatal Practice Guidelines-DHCS)			
12.5	Pregnancy/physical exam: Evidence of timelines met for physical examination requirements for pregnant/peri members.			

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12.6	Required treatment issues: Evidence required areas/issues included in treatment (see PPG, includes parenting skills); review of problem lists, referrals, Sign in sheets, Program scheduled (Title 22, Section 51341.1.) (Perinatal Practice Guidelines-DHCS)						

REQ #	WITHDRAWAL MANAGEMENT SERVICES/AWM	RESULT	FINDING	COMMENTS
13.1	If prescribed and/or OTC medications were self-administered during the episode, monitoring (including times taken) are logged. (Title 22, Section 51341.1) (BHIN 23-068)			
13.2	WM observation log is completed as required.			
13.3	There is documentation of development of referral plan. (MHSUDS INFORMATION NOTICE NO: 15-048)			