NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Behavioral Health Audit Manual

Revised July 2018

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Section 1:
Oversight Functions

The Division of Behavioral Health (Division) and Regional Behavioral Health Authorities (Regions), as contractually required, monitor, review, and perform programmatic, administrative, quality improvement and fiscal accountability and oversight functions on a regular basis with all subcontractors. If the Region is a direct provider of services, the Division is responsible for the oversight functions for the services provided directly by the Region.

The Region and Division use internal and external measures for oversight of services purchased through the contract between the Division and the Region.

External measures are performed by entities outside of the Nebraska Behavioral Health System (NBHS*), and include as appropriate:

1. Fiscal audit as conducted by a certified public accountant, and
2. Accreditation by a nationally recognized accrediting body

Internal measures are performed by entities within NBHS, and include:

1. Services Purchased Verifications (unit/fiscal)
2. Program Fidelity Reviews (programmatic)
3. Internal Controls (self-review & monitoring)
    a. In compliance with the COSO (Committee Of Sponsoring Organizations) documents:
        i. Standards for Internal Control in Federal Government
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The written procedures outlined in this document provide a systematic approach (across all Regions and the Division) to the oversight of network management, including the monitoring and reviewing of services in the network. Each Region is charged with developing Regional written procedures, consistent with the components outlined in this manual, for use in the review of services purchased from all subcontracted entities. Regions should include, at a minimum, all of the components included in the most recently agreed upon NBHS Audit Manual in their written procedures. Any changes made to the NBHS manual should be reflected in the Region's written procedures, and should be submitted to the Division with the fiscal year Regional Budget Plan. Unless otherwise agreed upon or required, the Division will use the Region's procedures and review forms when conducting reviews of Region-provided services for Services Purchased and Program Fidelity reviews.

Audit elements, policies and procedures may be continually revised subject to changes in health care reform and the role of other payers in auditing for quality and/or fidelity. Any updates to the Audit Manual will be communicated in conjunction on a quarterly basis throughout the fiscal year.

All consumers must be assessed for their ability to pay for services received in accordance with the provider policy as approved by the Region, and through use of the approved format. The Financial Eligibility Policy and resulting fee schedules are to be consistent with Regional policies, approved by the Division, and are to be applied consistently across all services.

These activities together demonstrate our commitment to fiscal accountability, continuous quality improvement, and organizational management of the NBHS service delivery system.

*NBHS – The Nebraska Behavioral Health System is composed of the Division of Behavioral Health, Regional Governing Boards and their contracted network of providers and state-operated Regional Centers.

Section 2:
Description of Oversight Functions

External Measures

Independent Annual Financial Audit by a Certified Public Accountant (CPA)

The purpose of the CPA audit is to assess the accuracy and reliability of provider accounting processes and financial reports.

National Accreditation

National Accreditation refers to the standards set by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organizations approved by the Director of the Division of Behavioral Health. Each accrediting body has a set of guidelines or program standards that define expected inputs, processes, and outcomes of programs and services. Accreditation bodies assess administrative, organization, and service delivery management of providers. Programs are accredited for conformance to nationally recognized service standards for a general field category that best describes the purpose, intent, and overall focus of a program.

Internal Measures

Services Purchased Verification

The Services Purchased (SP) Verifications are conducted to verify that services claimed for reimbursement have been delivered to a consumer and that expenses are verified in financial records and are allowable costs. There are two types of services purchased verifications: **unit verification** for fee for service (FFS) services and **expense verification** for non-fee for service (NFFS) services. These reviews are generally conducted at the same time as the program fidelity review, but can be completed at separate visits. Unit verifications for fee for services reviews should be completed within the fiscal year; expense verifications for services considered as non-fee for service may be completed no later than October 31 (with subsequent report to the Division by November 1 if a Corrective Action Plan is indicated) following the Fiscal Year under review.

An SP verification of services purchased includes a review of any documentation to verify that the services purchased were delivered. This can include clinical records, progress notes, financial records, and/or other documentation as deemed necessary. Services purchased verifications shall be conducted on a fiscal year basis for all services billed to the Region and to the Division under the contract as reflected by Authorization Turn-Around Documents (TADs) or other Division required supporting documentation. SP verifications must also include confirmation that the agency has written policies and procedures for “Internal Controls” and risk assessment. It does NOT require review or testing of those policies and procedures.

Program Fidelity Review

The purpose of Program Fidelity Review is to review program plans and services delivered to ensure consistency and conformance with service definitions, state regulations, policies and contract requirements governing mental health and substance abuse programming and specific federal community mental health or substance abuse prevention and treatment block grant program requirements. The Program Fidelity Review is conducted a minimum of once every three years. National accreditation may preclude the review of certain surveyed items as determined by Regional Network administration.

Internal Controls

Each organization shall develop and maintain written policies and procedures for internal controls, specifically including cash management, and determination of allowable costs. The goal of these policies and procedures is to create sound business practices to minimize the risk of fraud, or theft of an organization's funds or assets. A common internal control is a "separation of duties" requirement; all business activities are handled by at least two or more different employees, or by contractors outside the organization**.**

Financial Reliability of Sub-recipients

Federal requirements have strengthened oversight over Federal awards to include all pass through entities. Organizations are required to review the risks of a potential recipient prior to making an award. This risk assessment includes an ongoing review of these sub-recipients. *These requirements are outlined in the Federal Regulations at 2 CFR 200.311.* See this link for additional information: http://www.ecfr.gov/cgi-bin/text-idx?node=2:1.1.2.2.1&rgn=div5#se2.1.200_1331

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Program Fidelity Review

This process monitors program plans and services delivered to ensure consistence and conformance with SAPTBG requirements (interim services, tuberculosis and HIV requirements, subcontractor compliance and charitable choice) for agencies designated as, and providing services for, specified priority consumer populations (IV drug users, pregnant women, women with dependent children) This fidelity review is conducted a minimum of once every three years for those agencies who receive SAPTBG funds and is conducted at the time of the services purchased review.

Section 3:
Schedule of Audits for Current Fiscal Year

A list of the verifications or reviews to be performed is submitted to the Division by the Region as changes are made to the provider panel on an ongoing basis throughout the fiscal year. The following forms are used in this submission:

- *Contract Provider Service Summary (located in the EBS System):* includes a list of all providers funded by the Region by location and services provided in each location.
- RP-2a (Services Purchased Verification & Program Fidelity Review List): this form is submitted with the RBP and lists all services within the Region to be audited by the Region or by the Division if the Region directly provides the service. The Region should indicate on the form for each service the most recent Program Fidelity Review date, unless the review is to be scheduled for the upcoming fiscal year, in which case they should note the projected date of the review.
  Notes:
  - Services purchased verifications must be conducted each fiscal year. Each service listed on the form will have a services purchased review during the fiscal year. It is not necessary to list a date for this review.
  - Program fidelity reviews must be conducted at least every 3 years but may occur more frequently if the Region/Division chooses.

If the Region is a service provider, the scheduling of audits is a mutual responsibility between the Region and the Division. The need for the Division to audit Regionally-provided services should be reflected on the RP-2a.

For providers under Corrective Action Plans, the Division/Region will conduct follow up audits/reviews as prescribed in the Audit findings sent to the Provider.

When scheduling audits, the Division and Regions are encouraged to take into consideration the date of the provider's national accreditation review. However, this does not preclude either entity from doing the review in the same fiscal year as the national accreditation review.

Section 4:
CPA Audit

CPA audits are required of all Regions and some service providers (see the CPA Flow Chart on the next page of this manual). CPA audits of the Regional Behavioral Health Authority are due to the Division within the timeline requirements as specified in the contract. Provider fiscal audits, compilation financial statements (as applicable), or a review of financial statements (as applicable) from subcontracted service providers are due to the Region not more than nine (9) months after the end of the service provider's fiscal year, as reflected by the Region on the RP-2.

The Region shall complete a review of each service provider financial audit by a CPA firm. Documentation of the Region's review and comments shall be made available to the Division upon request along with the service provider's financial audit. A coversheet will accompany the CPA audit of the service provider that indicates:

- Date service provider audit was received and reviewed by the Region
- A cover sheet signed by Region staff reviewing with any material weaknesses and significant deficiencies identified, implications for findings, and other activity detailing Region oversight;

If material weaknesses or significant deficiencies are found, corrective action plan will be requested by the Region. The Region should notify the provider and include the following information (may be taken directly from the CPA audit):

- Finding number and name
- Criteria
- Condition/Context
- Cause
- Effect
- Recommendation

The provider's plan of correction should include:

- The condition/context listed on the :
- Recommendation given:
- Corrective action to be taken by the provider
- Supporting Documentation that will be submitted to demonstrate action taken:

Example of corrective action for federal finding:

Finding 2016-001: Timeliness of General Ledger Account Reconciliations (Material weakness)

Condition/Context: The agency did not have an adequate control systems in place to ensure the general ledger accurately reflects the account balances of the agency on a monthly or annual basis.
Recommendation: the Agency should evaluate its internal controls as the relate to the financial close and reporting process to ensure that accounts are properly stated throught the fiscal year and the audit is completed in a timely basis.
Corrective Action Plan: The agency has hired an experienced full time accountant in the field of governmental nonprofit healthcare to train and improve the accuracy of the general ledger.
Supporting Documentation included: Vita and letter of hire of new staff

Note: If this is a repeat finding, the Region should expect provider progress towards achieving compliance. For example, if an initial finding was a material weakness, has it been "downgraded" to a significant deficiency.

Audit Parameters:

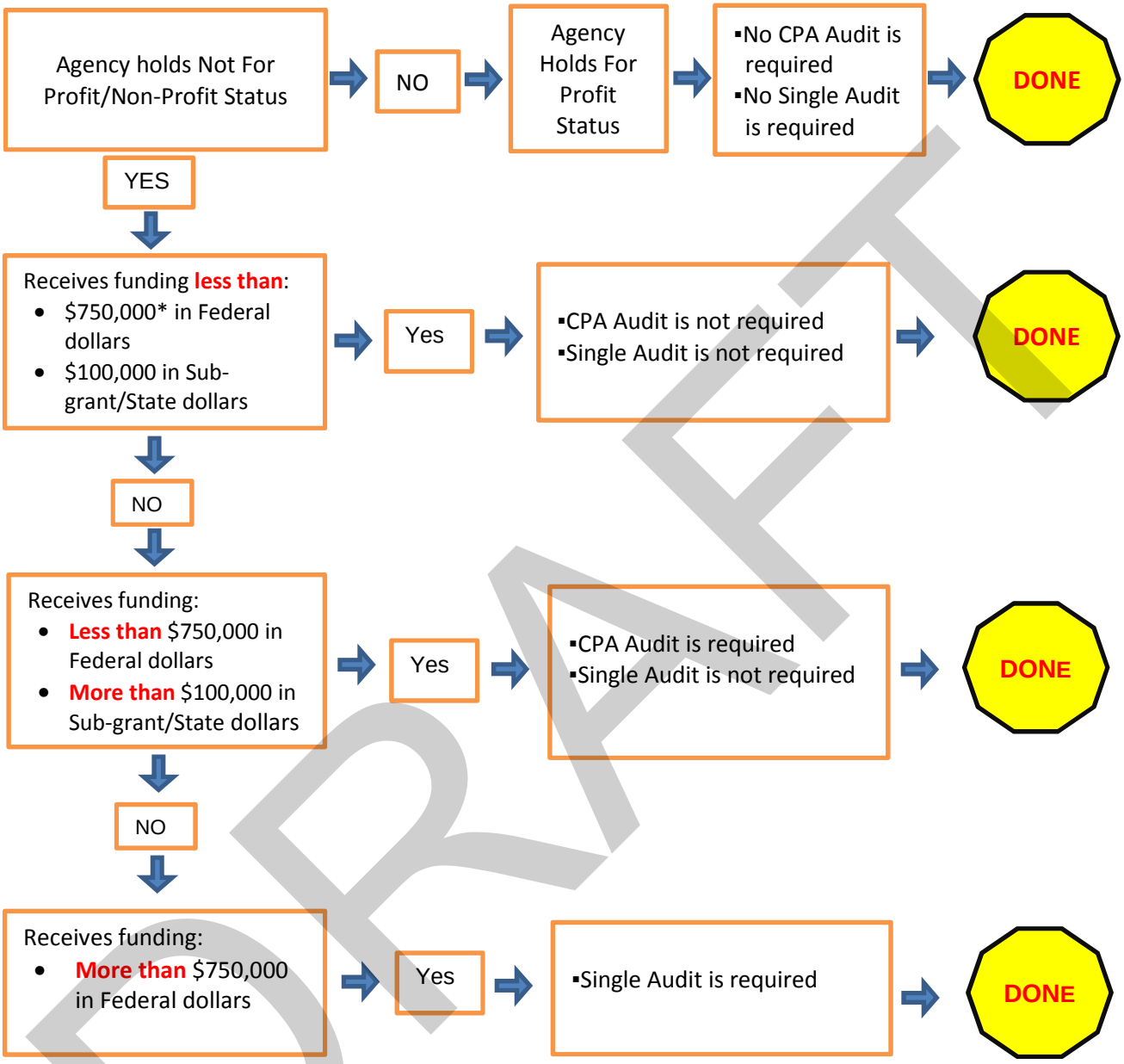
CPA audits of the Region must include a two year comparison of expenditures.

Expenditure Threshold under the Single Audit Act:

*Note: 2 CFR Part 200, raised the expenditure threshold under the Single Audit Act to $750,000 in federal funds for audits of fiscal years beginning after December 26, 2014 (i.e., for entities with fiscal year that ends on, or after, December 31, 2015). Furthermore, the cost of auditing an entity that is exempt from having an audit under the Single Audit Act due to having less than $750,000 in federal expenditures is **NOT** allowed to be allocated or otherwise charged to federal funds.

Agencies who hold For Profit status will not be required to submit a CPA audit nor a Single Audit document.

CPA Audit Flowchart



*The $750,000 Federal threshold for Single Audit Act applies to any entity expending federal funding regardless if they are expending federal funds received directly from a federal agency or from a pass-through agency such as the State and/or Region (see note on Pg. 7 regarding new threshold).

Federal grant funding always retains its identity as 'federal funds' and all requirements, expectations & restrictions follow those dollars through ALL sub-recipients, regardless of how far removed.

Financial statements and auditor's report must be submitted to DHHS within the earlier of 30 days after receipt of the auditor's report(s), or nine (9) months after the end of the provider's fiscal year as reflected on by the Region on the RP-2.

Section 5:
General Verification/Review Procedures

The following procedures apply to both the Services Purchased Verification and the Program Fidelity Review.

Pre-Visit

All Network Providers should receive Region specific policies and procedures, which includes purpose, methods and process for Program Fidelity Reviews and Services Purchased Verifications.

The Region will work with the Provider Agency to establish the review date. The Region will send a list of file names and other information to be reviewed no more than (2) days prior to the review for program reviews and ten (10) days for fiscal reviews. The agency shall have files available for the Audit Team at the appointed time and location.

The Region will develop a site visit agenda to be used on each review/verification of providers. Such a protocol will include a schedule of events, including any opening or exit meetings, and any other items of the process. Such an agenda may be given to the provider agency prior to/at the beginning of the verification/review.

Beginning the Verification/Review

Team members should arrive on site in a timely manner, at the time agreed upon with the organization, and locate the Agency/Program Director or designee for introductions. Review Team members should meet with management, designated staff members and any other individuals requested by the organization (e.g., Board Members) to attend the opening/orientation meeting. Team members should introduce themselves, and give a brief explanation about the purpose of the audit and the day's agenda/schedule. Program Staff are given the opportunity to explain the purpose/mission and key points about program operations, where information will be located, and organization of consumer files. Review staff may want to reference the Confidentiality Authority to review/verify files.

The Review Process

A room or work area should be made available for team members to review confidential records. See Sections 6 & 7 for procedures specific to Program Fidelity Reviews and Services Purchased Verifications.

Ending the Review/Exit Conference

An exit conference is the last meeting with management and designated staff (and others), to present a summary of findings and observations, including areas of strength and areas in need of improvement. The feedback given should be focused on compliance with the services purchased verification and program fidelity review standards and procedures.

Out of Region Network Providers

Regions who have letters of agreement with an out of Region provider may choose to audit the provider directly, or as the "home Region" to conduct the audit. When there is an agreement between a Region and Network Provider of another Region for a consumer to receive services out of region, the contracting Region, upon agreement with the non-contracted Region, pull units or expenses to audit the non-contracted Regions files. When applicable, the auditing Region can include the consumer in the review

sample but is not required to include the consumer in units reviewed. The contracted Region will share reviews/verifications as well as the CPA audit (if one is required) with the non-contracted Region. The Region who holds the LOA (non-contracted) should provide information to the contracted Region in a timely manner. The sample size should be inclusive of both the auditing Region and the non-contracted Region.

Post Review/Reporting

Following the onsite visit, a written report, providing a summary of the audit, will be completed and submitted to the provider agency within forty five (45) days of the visit. There shall be one report per provider agency but each service should be addressed separately within the report. Copies of the report will be made available to the Division upon request. A copy of the report shall be shared with other advisory or governing bodies.

A site visit satisfaction survey may also be distributed to agency providers after the review has been conducted.

Should the review result in the need for a Corrective Action Plan (CAP), the plan is due to the Region within 30 days of receipt of the audit report. A copy of the CAP will be forwarded to the Division upon receipt by the Region with the Region's final report and subsequent follow-up reports sent to the Division upon completion.

Item	Provider	Region
Services Purchased	NA	Report due to Provider Agency within 45 days; if CAP required, copy of original report sent to Division at time report sent to Provider Agency.
Program Fidelity	NA	Report due to Provider Agency within 45 days; if CAP required, copy of original report sent to Division at time report sent to Provider Agency.
CAP	Due to Region within 30 days	Due to Division upon receipt from service provider
CAP follow up reports	NA	Due to Service Provider within 45 days with copy to Division for all follow up audits until CAP resolved

Audit report summarizing the Services Purchased Verification and Program Fidelity Review findings per agency provider shall be given to the Regional Governing Board per fiscal year.

Service Provider Challenges to Services Purchased and Program Fidelity Audit Findings

For challenges that are Regulations based, refer to Title 206, Behavioral Health Services, Chapter 3 Division Administration (Amended 4/11/15), Section 3-004.

The process for challenges that are Contract Based is outlined below:

For Service Providers reviewed by Region personnel, follow the Region's grievance process.

For Service Providers who undergo the review process by Division staff:

1. Within 10 working days of the Services Purchased/Program Fidelity report, the service provider will make a written request for review to the Director of Behavioral Health.
2. Within 5 working days, the Division Director, or designee, will acknowledge, in writing, the Service Provider's request for review.

3. The Division Director serves as the decision maker for this process, and will issue a written decision to the Service Provider within 20 working days following receipt of the Service Provider's written request for review.

Confidentiality

All information concerning the identity of clients will be handled in a confidential manner (as provided in 42 CFR Part 2, 45 CFR Part 160, and 45 CFR Part 164) and providers may request that reviewers sign a confidentiality statement.

Section 6:
Services Purchased Verifications (Unit and Expense Verifications)

All services purchased must be verified on a Fiscal Year basis regardless if they are paid by the Region on a fee for service (FFS) determined rate or as non-fee for service (NFFS) expense reimbursement. This verification may be conducted in combination with the program fidelity review, or may be conducted as a stand-alone verification.

Services that are billed to the Region by a rate will be verified using the FFS process, regardless of how that service is paid in the State to Region contract. Services paid by expense reimbursement in the Region to Provider contract will use the verification of expenses methodology.

Services Purchased Verifications and Expense Verifications may be conducted together or separately. The deadline for completion of services purchased verifications is June 30 of the fiscal year under review. The deadline for completion of Expense Verification Reviews is November 1 following the fiscal year being reviewed in order to allow a more thorough review of June expenditures. The final report for Expense Verification Reviews is due December 15.

Audit elements, policies and procedures may be continually revised subject to changes in health care reform and the role of other payers in auditing for quality and/or fidelity. Regions will be notified in writing 30 days prior to the effective date of any change.

FFS Services Purchased Verification (Unit Verification)

Pre-Visit:

The unit sample of services purchased is selected from the provider agency's billing documents submitted to the Region including the Turn-Around Document (TAD), Provider Log or other Division required documentation for authorized or registered encounter units submitted with provider billings of the current fiscal year. In some cases a monthly provider log is submitted in lieu of a TAD and therefore would be reviewed to determine the services purchased sample.

At a minimum, the verification must review a random selection of two-percent (2%) of the services purchased during the fiscal year for all mental health and substance abuse services, with a minimum of five (5) files total. Source documentation for establishing the 2% sample size is the provider's current contract at the time of the audit. Audits of providers with low initial monthly utilization may be scheduled at later dates. All files within that service will be reviewed if less than the 5 file minimum.

The randomly-selected services purchased verification must be from at least two (2) non-consecutive months within the same fiscal year the services were purchased and must include services purchased from all service. It may be necessary to pull additional months/units as needed to obtain the minimum 5 files.

Process:

Compliance for audits shall be scored on a Yes / No basis. 95% compliance is the minimum acceptable threshold for services purchased verifications.

Payback will be sought for:

a. Services provided are not verifiable in the agency's consumer/program records
b. Services provided do not agree with the reimbursement claim with respect to date, type, and length of service

c. Services provided do not meet the appropriate service definitions
d. Consumer is ineligible according to the NBHS Financial Eligibility and Fee Schedule;
e. Service provision is found to have been provided by an individual without the appropriate licensure as defined by NBHS service definitions

If applicable, the Region should pull files of 2-3 individuals that were found to be Medicaid eligible in the reporting period being sampled. The Region should trace payment back to ensure any retro eligible units were not charged to the Region within the fiscal year.

If a service provider scores less than a 95% compliance rate, the Region/Reviewer shall expand the sample to 5% of contracted units (an additional 3%). In the event that the original 5 file minimum sample exceeded the 5%-sample size, no additional files will be reviewed. Expansion is typically done on-site during the day of the initial audit, however, can be scheduled on a separate date.

Payback of 100% of non-verified units regardless of compliance level will be required. Paybacks must include the encounter number and date of service.

Regions should verify that when a provider is billing for someone with insurance and the claim was denied, the provider is billing the Region within 30 days of the date of insurance denial.

Post Review and Reporting

Components of the review report shall include:

- Name of agency and service audited
- Services Purchased (SP)
  - Contracted units for the service based upon fiscal year unit totals
  - 2% sample of contracted FY units as determined at the time of the audit
  - Number of files audited
  - Months that were audited
  - Number of units verified
  - Percent of units verified
  - Percent of compliance

Coversheets and detailed documentation (e.g. Worksheets) that service being paid for was being provided and within the scope of practice of the clinician providing the service.

The Region has 45 days from the date of the first audit (or date of expansion, if another date) to write a report on the findings of the review to be distributed to provider. When the 95% compliance threshold is not reached in the (expanded) 5% sample, the provider is considered to have not met the required compliance threshold in the review and a Corrective Action Plan (CAP) is required.

The CAP will be submitted to the Region within 30 days of the time of receipt of the audit summary. In all instances, service providers will be given a reasonable length of time (30 to 90 days), depending on the scope of deficiencies, to make the needed corrections and submit follow-up documentation (if indicated).

If the service provider does not take corrective action, or does not submit needed documentation for corrective action by the due date, the Region shall withhold payment from the service provider for the identified service(s) until such required documentation is received by the Region.

If similar or additional sanctions are required in successive fiscal year audits and/or financial reviews, or if corrective actions are not made, additional sanctions will be imposed. These sanctions could include, but are not limited to, requiring additional Corrective Action Plans, termination of purchasing the specific service from the provider, or termination of contract with the provider. In any case, payback will be required for any units not verified.

Re-audit shall occur within 60-90 days following receipt of the CAP. The re-audit shall consist of 5% or a minimum of 5 files of the State fiscal year total units contracted, and units shall be drawn from the months since the CAP was submitted.

Corrective Action Plans, copies of the initial review, the resultant CAP, and follow-up review reports will be sent to the Division.

Item	Provider	Region
Services Purchased Verification	NA	Report due to Provider within 45 days; if CAP required, copy of original report sent to Division at time report sent to Provider
CAP	Due to Region within 30 days	Due to Division upon receipt from provider
CAP follow up reports	NA	Due to Provider within 45 days with copy to Division for all follow up audits until CAP resolved

Reviewing CAP's that Cross Fiscal Years

The re-review process for CAPs that cross fiscal years will be the same as a normal Services Purchased Unit and Expense Verification, and the re-audit may be incorporated within the normal Fiscal Year Audit. Re-audit shall consist of 5% or a minimum of 5 files for those services in which a CAP was in place. All other services will follow normal Services Purchased processes. In the rare instance that the provider is not in compliance and payback is required, request payback; if problems arise, they will be handled on a case by case basis in consultation with the Division.

Medical and Therapeutic Leave Sample

Regions should develop a process to ensure that medical and therapeutic leave are being audited.

NFFS Services Purchased Verification (Expense Verification)

All services purchased on an expense reimbursement basis must be verified annually. This may be conducted in conjunction with a unit and/or program fidelity review or as a separate verification. Expense verifications for services considered as non-fee for service may be completed after June 30 but must be completed no later than November 1 following the fiscal year being reviewed.

Pre-Visit:

The Region Finance Director or designee will determine the months to verify and notify the agency at least 10 days in advance of the visit. At a minimum, two non-consecutive months of documentation must be reviewed for each service for each contract year. The provider will be notified of the months to be reviewed and the documentation that will be needed by the reviewer. This includes, but is not limited to:

- General Ledger (GL) for service(s) being reviewed,
- Payroll, receipts, mileage reimbursement, time sheets, and other expense verification documents,
- Canceled checks or other warrants used for payment of expenses claimed,
- Internal worksheets that were used to create expense reimbursement to the Region,
- Cost allocation charts or basis, and,
- Client files as necessary for the service(s) being reviewed (e.g., financial eligibility, flex funds).

Procedures for Each Service Being Reviewed:

1. Select a sample of five (5) client files from the service being verified and determine client financial eligibility was established. This may be completed in conjunction with or as part of a Program Fidelity Review or unit verification. Client file review may be waived for a service if participation in the service requires enrollment in another DBH service where financial eligibility is determined (i.e., Housing Assistance). An affirmative statement to any waiver of client file review must be made either in the Pre-visit correspondence or in the Post Review report.

2. Verify that total expenses reflected in the GL can be traced to the billing amount submitted to the Region/State. This will include verifying that any revenue received/generated by the service was deducted from the total expense and the adjusted expense amount was billed to the Region/State.

3. Randomly select at a minimum two non-employee expenses and two employee related expenses (e.g. mileage reimbursement) for each service. Verify that receipts and documentation of payments exist and are reflected in the correct expense account. It is recommended that the expenses being selected include a large or non-recurring expense as well as recurring costs. If appropriate documentation cannot be located for an expense, document the missing items and select an additional expense to verify.

4. If the expense being reviewed is part of a larger bill, determine how the amount was allocated to the service and if this is reasonable and allowable within contracted budget amounts for categories. If employee salary or wages are split between multiple services, determine how the compensation was allocated to the service being reviewed for reasonableness and accuracy.

5. Verify that payments received from the Region or other payers were credited to the services as billed.

6. During the review, note any trends or areas of needed improvement identified. If the identified areas could pose a financial risk to the agency under review or the Region/State (e.g., lack of or poor supporting documentation), a corrective action plan may be required to minimize the risk.

7. If the service is paid based on a 1/12th payment, expenses for the months under review as outlined in steps 2 through 5 listed above must be conducted. In addition, a year-to-date analysis of revenue received and expenditures charged must be completed to determine that YTD revenues do not exceed YTD expenses by 5% or more. If revenues exceed expenditures by 5% or more, future payments in the fiscal year should be adjusted to minimize pre-payment of expenses. If the YTD analysis is completed after the fiscal year, any funds received in excess of the YTD expenses charged to the service must be repaid.

8. When auditing a file of a consumer who has been moved to Medicaid, check the date of eligibility to ensure any retro billing for Medicaid and unbilling for DBH has occurred.

If less than five percent (5%) of the expenses in the service cannot be verified or are unallowable for the months reviewed, no expansion is required. Payback is determined based on the amounts determined to be unallowable or unverified.

If more than five percent (5%) of the expenses for one or both of the months in the service cannot be verified or is deemed to be unallowable, the sample must be expanded to include a third (3rd) month of expenditures for that service. The additional month of expenditures will be reviewed as outlined in steps 2 through 5 listed above. If the expenses can be verified in the third month, any expenses determined to be unverified or unallowable in the first two months will be required to be repaid to the Region/State and a Corrective Action Plan will be required.

If more than five percent (5%) of the expenses cannot be verified for the third month reviewed, the sample must be expanded to include all months paid for the service during the fiscal year. Payback will

be determined based upon the total unverified or unallowable expenditures for all months reviewed. A corrective action plan must be required in this situation.

When a corrective action plan is written and covers multiple locations, a process must be in place for each location to correct errors.

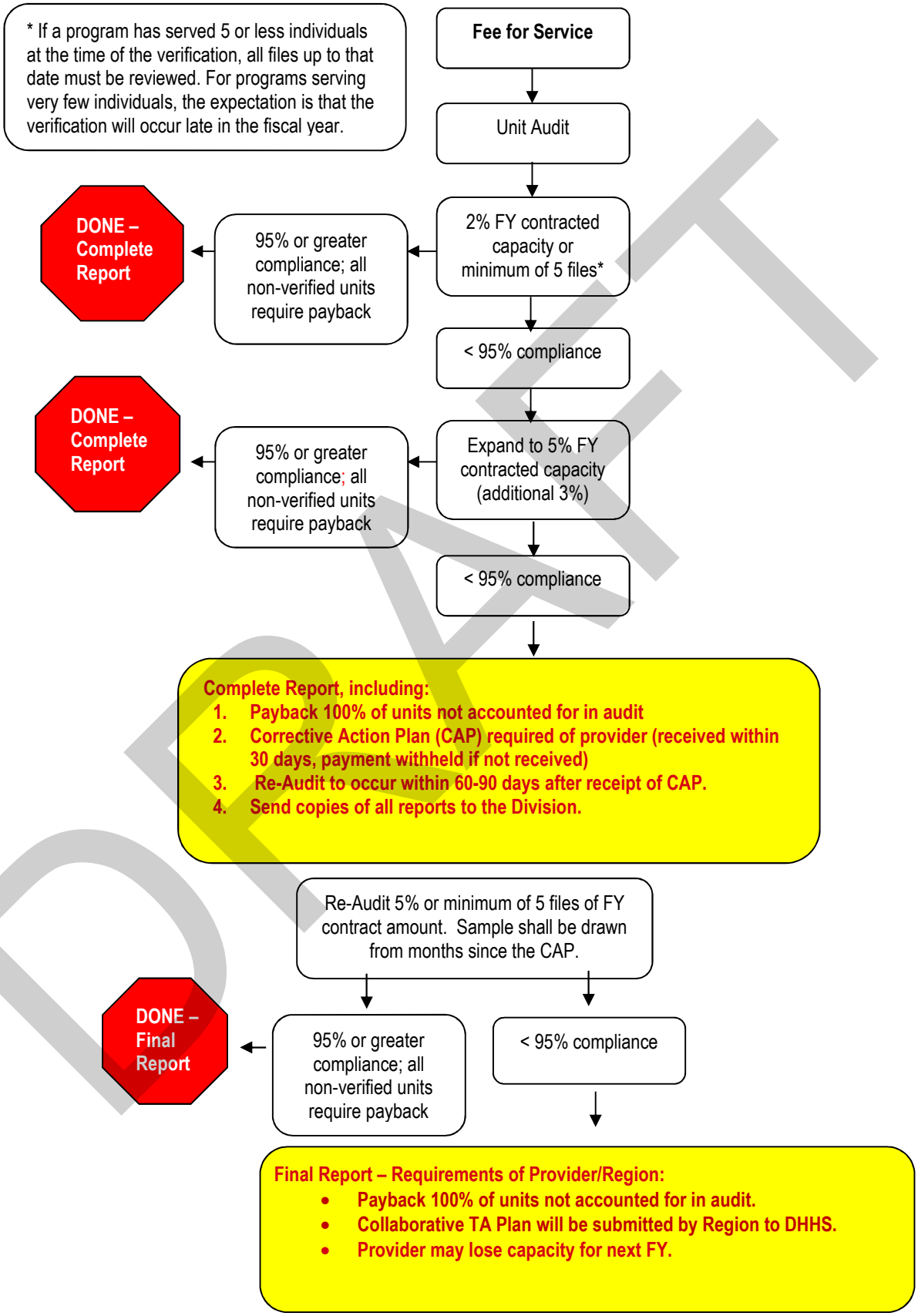
Post Review and Reporting:

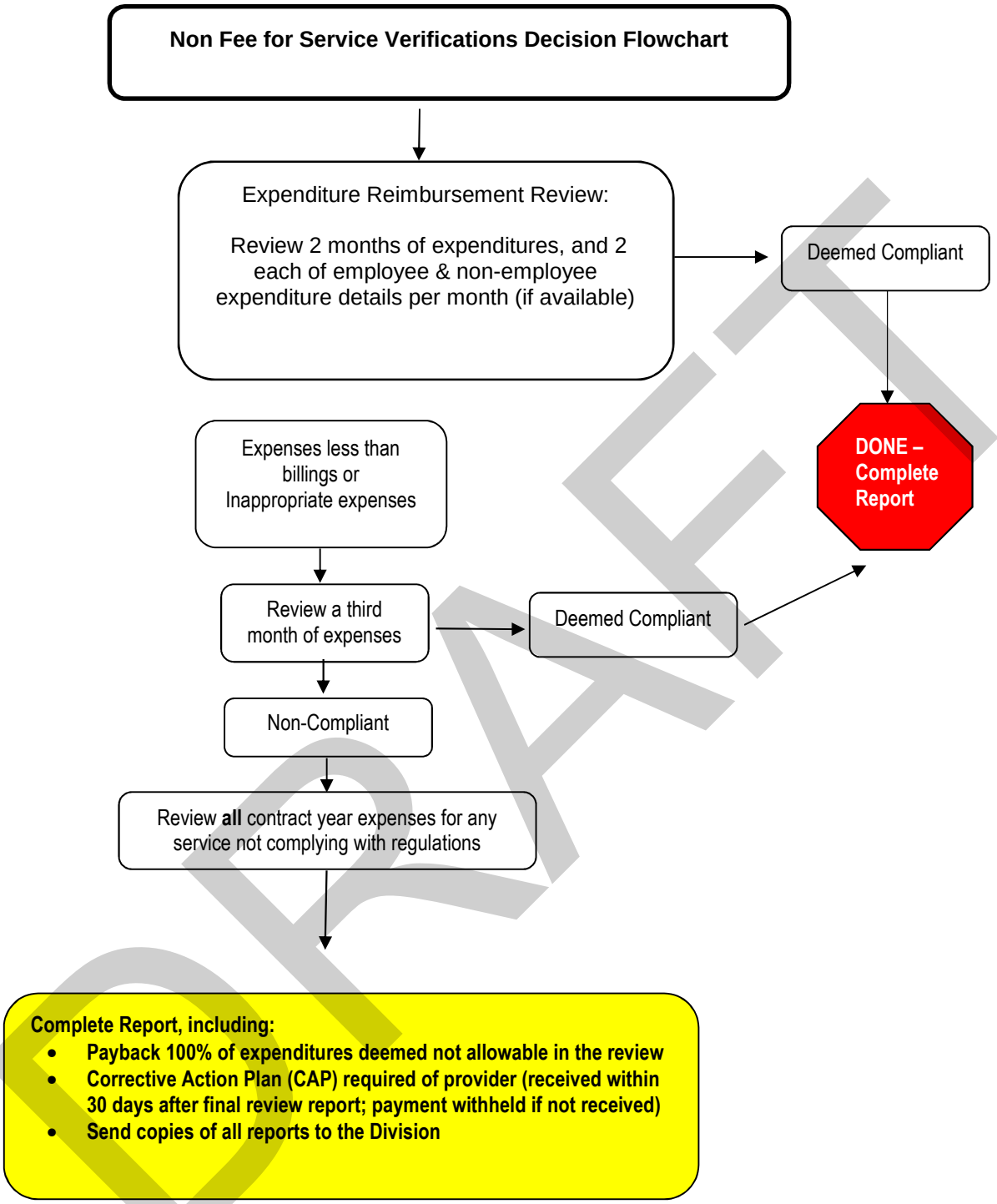
A written report, providing a summary of the audit, will be submitted to the provider and made available to the Division upon request. A copy of the report shall be shared with other advisory or governing bodies.

Final reports shall be written, within forty five days (45) of the completed audit or re-review. The report may be sent separately from the Services Purchased Verification review. Components of the report shall include:

- Name of agency
- Listing of documents that were reviewed
- Listing of expenses and months that were reviewed
- Narrative of findings
- Corrective actions required
- General comments and observations

Services Purchased Verification Decision Flowchart




Non Fee for Service Verifications Decision Flowchart
Expenditure Reimbursement Review:
Review 2 months of expenditures, and 2 each of employee & non-employee expenditure details per month (if available)
Deemed Compliant
DONE – Complete Report
Expenses less than billings or Inappropriate expenses
Review a third month of expenses
Deemed Compliant
Non-Compliant
Review all contract year expenses for any service not complying with regulations
Complete Report, including:
Payback 100% of expenditures deemed not allowable in the review
Corrective Action Plan (CAP) required of provider (received within 30 days after final review report; payment withheld if not received)
Send copies of all reports to the Division

Section 7:
Program Fidelity Reviews

Program Fidelity Review Process

Program Fidelity Reviews shall be conducted on each service at a minimum of once every three years, and can be conducted at the same time as the services purchased verification. The reviews determine compliance with applicable state statutes, state and federal rules and regulations, state service definitions, and other mandatory guidelines for service provision.

DBH and the Region will maintain the prerogative to review all items in the respective protocol regardless of accreditation status. Review elements, policies and procedures may be continually revised subject to changes in health care reform and the role of other payers in auditing for quality and/or fidelity. Regions will be notified in writing 30 days prior to the effective date of any change.

Substance Abuse Program Fidelity Reviews addressing block grant standards will also be conducted at a minimum of once every three years for all providers receiving Substance Abuse Block Grant funding, addressing requirements for all priority populations. The Substance Abuse Prevention and Treatment Block Grant Program Fidelity Review will be used for this review. (See Appendix A).

Pre-Visit:

Program Fidelity Reviews shall include of a minimum of three (3) files per service, per provider, and must examine files for services provided in the current fiscal year being reviewed. Reviewers can choose from files being examined as part of the services purchased verification, or can use the TADs or provider logs or other Division required documentation as applicable to choose three separate consumer files for review.

The Program Fidelity Review shall also evaluate other documentation including programmatic plans and clinical details of the service that are sufficient to verify that the services provided comply with state regulations and service definition components.

Process:

Reviewer examines the three (3) client files and program documents to ensure compliance with service definitions, rules and regulations, and other mandatory guidelines. When, in the judgment of the reviewer, a material number of errors are encountered in the initial sample, the sample size will be increased by 2 files (5 files total).

Substantial compliance is necessary for the service to pass the program fidelity audit. The following considerations are made when determining whether the provider passed or failed:

- Number of recommendations
- Type of recommendations required
- Patterns or trends in files from various programs
- Multiple reviewers encountering same issues – reviewer consensus

Post-Visit:

Components of the review report shall include:

- Name of agency and service audited
- Program Fidelity (PF)
  - Number of files reviewed

    - Identify whether PF was substantially met
- Number of exceptions for SP & PF
- Specific Unit and Program Review observations
- Suggestions / Recommendations
- Corrective actions required
- General comments / observations

The Region shall complete a report detailing the results of the review and distribute it to the provider within 45 days of the visit. If the review indicates less than substantive compliance, the report shall require the provider to complete a Corrective Action Plan (CAP) detailing how they intend to correct the components not meeting compliance. CAP shall be submitted to Region/Division within 30 days of the notification that the provider did not meet compliance standards in the review.

Upon receipt of the CAP, the Region/Division may provide technical assistance (TA Plan) to the provider. Another available option is to put the provider on probationary status with re-review of the service(s) within the current year, or, depending upon the severity of the transgression(s), wait until the next fiscal year's review.

If the provider does not take corrective action, or does not submit needed documentation for corrective action by the due date, the Region shall withhold payment from the provider for the identified service(s) until such required documentation is received by the Region. If similar or additional sanctions are required in successive program fidelity reviews, or if corrective actions are not made, additional sanctions will be imposed. These sanctions may include, but are not limited to, requiring additional Corrective Action Plans, termination of purchasing the specific service from the provider, or termination of contract with the provider.

Copies of the initial review, the CAP and subsequent follow-up review reports are to be sent to the Division. However, if the Provider does not receive federal funds, the CAP does not need to be submitted to DBH. Eliminate this provision.

Item	Provider	Region
Services Purchased Verification	NA	Report due to Service Provider within 45 days; if CAP required, copy of original report sent to Division at time report sent to Service Provider
CAP	Due to Region within 30 days	Due to Division upon receipt from service provider
CAP follow up reports	NA	Due to Service Provider within 45 days with copy to Division for all follow up audits until CAP resolved

Section 8:
Internal Controls and Sub-recipient Monitoring

Internal Controls

Each organization is responsible for establishing written policies and procedures for a system of internal controls. As outlined in 2 CFR 200 these internal controls must comply with the COSO (Committee Of Sponsoring Organizations) documents:

- *Standards for Internal Controls in the Federal Government*
- *Internal Control – Integrated Framework*

The websites for COSO and the COSO Internal Control documents are:

- http://coso.org/default.htm
- http://coso.org/IC.htm

An organization's Internal Controls must include policies regarding Cash Management and Allowable Costs. Additional information and reference details may be available at the following websites:

- Council on Financial Assistance Reform: https://cfo.gov/cofar/
- National Council of Nonprofits: https://www.councilofnonprofits.org/

Monitoring of Sub-recipients

Regulations require organizations to review the financial reliability of sub-recipients. This monitoring is required both prior to the sub-recipient award and ongoing through the award period. State of Nebraska regulations require the use of a form or checklist to verify this review.

Sub-recipient monitoring includes a review and follow-up of any audit findings for that agency. The use of a formal document such as a checklist is required. An example of such a checklist may be available from DBH.

Your agency MUST verify that all sub-recipients have written policies for internal controls. These internal controls must include polices covering Cash Management and Allowable Costs, as outlined in the Internal Controls section above. Your responsibility is only to VERIFY that the entity has these written policies. Testing for compliance of these internal controls shall be determined and done by the sub-recipient's CPA auditors.

Section 9:
Division Required Registration and Authorization

Provider Logs

Unless otherwise stated in contract (i.e., 24 hour crisis line, crisis response teams), all services for which reimbursement is requested from NBHS should be registered and/or authorized through the Division's required documentation procedure. Registration and pre-authorization occurs on-line or is captured in a provider log.

All registration information shall be entered as the data is required for the State to fully meet Federal Block Grant reporting requirements. NBHS and national accreditation standards require that an organization have and/or participate in an organized information management system which includes timely collection of information, use of data for decision making and improvements in the efficiency and productivity of staff.

Turn-Around Document (TAD)

A TAD is available on-line at the end of a billable month. A provider accesses the Division required documentation menu on-line and accesses a document indicating, by service and by client and by dates of service, authorized service units for the billable month. The provider enters encounter data (the number of units of service actually provided to the consumer for the month). This report is printable.

A TAD is available for NFFS services indicating persons registered for the service. Encounter units shall be entered by provider and used as a basis for selection of files audited. TAD reports are available on-line to designated agency staff, Regional Administration staff, and Division staff.

Discharge Form

If reviewing the file of an individual who has been discharged, a discharge reporting form should be in the file. The discharge reporting form is obtained from the CDS. The Division authorized system's provider handbook and other updated forms can be found on the CDS.

Provider Logs

A Provider Log is maintained at the Region and is used when a service is neither registered nor authorized with the Division's authorized system as determined (excluding service enhancements and flexible funding). The purpose of this information allows DBH the ability to quantify numbers of consumers served with NDBH funding as well as the opportunity to cross reference consumers who may be receiving services in two or more areas.

Consumer information required in this Log includes:

- Region Identification
- Provider Number
- Provider Name
- Service Type/Service Received
- Consumer Social Security Number
- Consumer Birthdate
- Consumer First Name
- Consumer Last Name
- Month(s) of Service Provided/Number of Units Provided

Appendix A

MH-SUD	Adult or youth	Service	CDS Units indicate:	EBS Payment
MH-SA	Adult	24 Hour Crisis Line	1 indicates person served	ER
MH-SA	Adult	24 Hour Crisis Line Rural	# of hours	Rate* # of hours
MH	Adult	Acute Hospital/subacute	# of days	1 day
MH	Adult	ACT	# of days	1 day
MH	Adult	Client Assistance Program		ER
MH-SA	Adult	CS	1 indicates person served 12 15 minute units or more	monthly rate
MH-SA	Adult	CS	# of 15 minute units provided	rate*15 minutes
MH	Adult	Crisis Assessment	1 indicates one assessment	ER
MH	Adult	Crisis Assessment-R6	1 indicates one assessment	per assessment
MH/SUD	Adult	Crisis Response	# of 15 minute units provided	ER
MH/SUD	Youth	Crisis Response	# of 15 minute units provided	ER
MH	Youth	Crisis Inpatient	# of days	rate*# of days
MH/SUD	Adult	Crisis Stabilization	# of days	ER
MH	Adult	Day Rehab	# of 5 hour or > sessions	rate*# of sessions
MH	Adult	Day Rehab	# of sessions 3-5 hours	rate*# of sessions
MH	Adult	Day Support	# of days attended	ER
MH	Adult	Day Support	# ofdays attended	rate*# of days
MH	Adult	Day Treatment	# of days attended	rate*# of days
MH/SUD	Adult	Dual Res	# of days attended	rate*# of days
MH	Adult	Emergency CS	# of contacts	ER
MH	Adult	Emergency CS	1 = served during the month	monthly rate
MH	Transition	Emergency CS Trans. Age	1=served during the month	monthly rate
MH/SUD	Adult	Emergency Flex Funds		ER
MH	Adult	EPC	# of days served	rate*# of days
MH	Adult	EPC	# of days served	ER
MH	Adult	Emergency Psych Observation	# of days served	rate*# of days
MH	Transition/Adult	Emergency RCS	1 indicates person served	ER
MH	Adult	Flex funds-CS		ER
MH	Youth	Flex funds FEP		ER
MH	Adult	Homeless Transition	1 indicates person served	monthly rate
MH	Adult	Hospital Diversion <24	1 indicates person served	ER
MH	Adult	Hospital Diversion >24	# of days served	ER
MH /SUD	Adult	IPPC	# of days served	rate*# of days
MH/SUD	Adult	Intensive Case Mgmt.	1 indicates person served	monthly rate
MH/SUD	Adult	Intensive Com. Servc.	1 indicates person served	rate*person served

MH	Youth	IOP	# of 50 Minute sessions	rate*# of sessions
MH	Youth	IOP		ER
SA	Adult	IOP	# of hours	rate*number of hours
MH	Adult	Interpreter Services		ER
MH/SUD	Adult	Med Support		ER
MH	Adult	Medication		ER
MH	Adult	Med Management	# of 15 minute units provided	rate*# of units
MH	Youth	Med Management	# of 15 minute units provided	rate*# of units
MH	Youth	Prevention/Promotion		ER
MH	Adult	Respite	# of days served	rate*# of units
MH	Youth	MST	1 indicates youth served	ER
Dual	Adult	OP - I, F,G	# of 50 minute sessions	rate*# of units
MH/SUD	Adult	OP - I, F,G	# of 50 Minute sessions	rate*# of units
MH	Youth	OP-FEP I-F	# of 50 Minute sessions	rate*# of units
MH/SUD	Youth	OP	# of 50 Minute sessions	rate*# of units
MH	Adult/Youth	OP CAG-Rate Enhancement		ER
MH	Youth	Service Enhancement		ER
MH/SUD	Adult/Youth	Peer Support	1 indicates youth/adult served	ER
MH	Adult	Plans for One		ER
MH/SUD	youth	Prevention/Promotion		ER
MH	Youth	Professional Partner	1 indicates youth/adult served	monthly rate
MH/SUD	Adult	Psych Emergency Room		ER
MH	Adult	Psych Res Rehab	# of days served	rate*#of days
MH	Adult	Recovery Support	1 indicates adult served	monthly rate
NM/SC-MH/SUD				ER
MH	Adult	Secure Res	# of days served	rate*#of days
MH	Adult	Secure Res r/b		rate minus revenues
MH/SUD	Adult	Supported employment	1 indicates milestone achvd	milestone payment
MH	Transitional	Supported employment	1 indicates milestone achvd	ER
MH/SUD	Adult/Trans	Supported Housing	1 indicates person served	ER
MH	Adult	Supportive Living	1 indicates person served	ER
MH	Adult/Youth	FEP team meeting	# of units provided	rate*# of units provided
MH	Youth	Therapeutic Consultation	1 indicates person served	rate*# of units provided
MH/SUD	Trans Age	Youth transition service	1 indicates person served	ER
MH	Adult	Urgent Med Mgmet	1 indicates person served	ER
MH	Adult	Urgent OP	1 indicates person served	ER
SUD	Adult	Assessment	1 indicates person served	rate*# of units
SUD	Youth	Assessment	1 indicates person served	rate*# of units
SUD	Adult	Client Asst. Program	1 indicates person served	ER

SUD	Adult	CPC	# of days served	rate*# of units
SUD	Adult	Crisis Assessment	1 indicates person assessed	rate*# of units
SUD	Adult	Halfway House	# of days served	rate*# of units
SUD	Adult	IOP	# of hours served	rate*# of units
SUD	Adult	Intermediate Res	# of days served	rate*# of units
SUD	Youth	Prevention		ER
SUD	Adult	Short Term Res	# of days served	rate*# of units
SUD	Adult	SOAR		ER
SUD	Adult	Social Detox	# of days served	ER
SUD	Adult	Social Detox	# of days served	rate*# of units
SUD	Adult	Therapeutic Community	# of days served	rate*# of units

Appendix B
Medical and Therapeutic Leave Addendum as Defined in 206 Regulations

Medical Leave Days
Beds in Psychiatric Residential Rehabilitation, Therapeutic Community, Intermediate Residential and Dual Disorder Residential Treatment and Secure Residential programs can be held up to 10 consecutive days per episode when a consumer is hospitalized for a period of medical/psychiatric stabilization and expected to return to the facility.

Individuals in ACT are allowed up to 10 consecutive days per episode when a consumer is hospitalized for a period of medical/psychiatric stabilization and the ACT team is actively involved in the planning for return to the community and the individual is expected to return to ACT.

Documentation of the need for stabilization is reflected in the consumer's treatment plan and file. The program will be reimbursed at the full program rate per day. This reimbursement is only available if the treatment placement is not used by another consumer. The Behavioral Health Managed Care Contractor must be notified within 24 hours of hospitalization and will reflect this information in the clinical database. More than 3 episodes in a calendar year will result in a Level of Care review. Leaves in excess of 10 consecutive days must be approved by the Department or its designee and requested through the Managed Care Contractor.

Therapeutic Leave Days
Beds in Psychiatric Residential Rehabilitation, Secure Residential, Therapeutic Community, Intermediate Residential, Dual Diagnosis, and Halfway House programs can be held up to 21 days annually (from the date of admission) when a consumer is on therapeutic leave for the purposes of testing ability to function at and transition to a lesser level of care. This reimbursement is only available if the treatment bed is not used by another consumer.

Individuals discharging from Assertive Community Treatment (ACT) may be allowed a 30 day period of transition when graduating and moving to a lower level of community service (outpatient therapy, medication management, community support mental health, and community support substance use disorder or day rehabilitation).

The therapeutic rationale and leave time period must be indicated in the treatment plan. Documentation of the outcome of the therapeutic leave and the need for continued residential level of care must be indicated in the consumer's record. The Department will reimburse at the full program rate per day. The Behavioral Health Managed Care Contractor must receive prior notification. Leave in excess of established time frames (21 days or 30 days for ACT per annum) must be approved by the Department or its designee and requested through the Managed Care Contractor.

Appendix C –
Mandatory review to be included upon review of files or national accreditation report

Substance Abuse Residential Audit List

Client files must include the following:

A. Initial treatment information:

-Copy of completed admission form in participant file
-Admission dates in claim agree with dates in file
- Documentation consumer and/or guardians gave informed consent to treatment, rehabilitation and/or recovery services, medication usage and services to be provided, as appropriate.
- Documentation of risks and benefits of every service for which consent is sought, and right to refuse service are explained to the consumer at an educationally appropriate level to individual.
-Proof consumer meets financial eligibility criteria (family income, number of dependents) (P)
-Proof of completed re-verification process every year to ensure continuing eligibility
-Proof of completed verification process upon admission to ensure participant is indigent
-Signed copy of citizen attestation.
-Copy of completed consumer assessment, including the following
-Assessment completed within timeframe per agency policy
-Assessment verifies participant meets eligibility requirements set by service definition
-Recommendations for services to include medical and/or psychological referral
-Licensed personnel signature, and, signature of fully licensed clinician approving this assessment
-Emphasis on strengths (P)
-Assessment of needs (P)
-Referral source (P), name and title of referral individual such as MD, psychologist, APRN, LIMHP
-Consumer name, Medicaid identification number, emergency contact (name, relationship, and contact information), and any other relevant consumer information.
-Prior treatment plan(s), as appropriate.
-Provider demographics including:
-provider name, address, phone, fax, e-mail and other contact information.
-Clinical impressions must be completed by a licensed clinician within their scope of practice, including information that supports/justifies recommendations made and integrating mental health and substance use co-occurring disorders, as well as:
-DSM diagnosis, Axis 1-5
-Primary/ideal level of care
-Available level of care/barriers to ideal level of care
-Documentation of consumer/family's response to recommendations

-Goals that the consumer wants to accomplish

B. Personal information and history:

-Employment history & strengths
-Educational history & strengths
-Military service record (DD214)
-People in the individual's life, including:
(1) Family members (age and level of involvement with consumer),
(2) Adult or minor children (names, ages and level of involvement), and,
(3) Other significant people and level of involvement
-Parenting knowledge or skill level, history of system involvement (courts)
-Social supports utilized by consumer (previous and current)
-Housing (ability to maintain housing, type of current housing, need for assistance)
-Recreational activities (consumer's preferences)
-Collateral information, and, consumer strengths as perceived by consumer and collateral contacts

C. Medical records:

-Emergency medical information including physician contact information and the telephone number of emergency contact
-Proper ROI form(s) completed in its entirety, including (P):
-Signature of professional, participant, and/or parent/guardian signature, as applicable
-One (1) year scope
-Documentation which allows the Division, its agent, and Region to receive confidential participant information
-Documentation that orientation was completed (P)
-Voter registration documentation (P) (include Form name?)
-Participant rights documentation (P)
-Grievance procedures documentation (P)
-Clearly defined participant expectations (P)
-Access to records
-Right to refuse Treatment
-Copy of completed payment agreement, including appropriate personnel, participant, and/or parent/guardian signature(s), as applicable

D. Health information:

-Communication with family and friends
-Psychosocial state (P)
~~Includes -~~Medical history, including (P):
-Current primary care physician (name and contact information)
-Date of last physical exam and the physician who performed exam
-Dental history and current needs
-History of trauma (physical, emotional, mental, sexual)(P)

-List of current medications (P)
-Chronological listing of medications prescribed (including dosages and schedule) for consumer and consumer's response to the medication.
-Compliance with medication (historical and current)
-HIV screening: yes/no (P)
-TB screening: yes/no (P)
-Pregnancy screening: yes/no (P)
-IV drug use screening: yes/no (P)
-Hepatitis B screening: yes/no
-Gambling addiction screening: yes/no
-Any follow-up for positive screening of screenings above (P)

E. Psychiatric/behavioral health information:

-Current diagnosis
-Board of mental health commitments (reasons and dates of commitment)
-History of abuse (to include sexual abuse, physical abuse, emotional abuse, neglect, witness domestic violence, victim/witness of community violence, physical assault)
-History of trauma (serious accident/injury, sexual assault/rape, life-threatening medical illness, traumatic loss of a loved one, terrorist act, war/political violence/torture, disasters {tornado, earthquakes}, sanctuary trauma {trauma while institutionalized}, prostitution/sex trafficking).

F. Substance abuse information:
-Primary drug(s) of choice;
    -amount, frequency and duration of use
-Current compliance with relapse prevention plan
-Periods of abstinence (supports needed)
-Tolerance level/withdrawal/history of complications from withdrawal
-Any prior alcohol/drug evaluations/recommendations
-Family history of alcohol/drug use
-Any other addictive behaviors

G. Legal information:

-Legal history (information from Criminal Justice System) to include criminal history and consequences of criminal involvement
Legal history includes connection to alcohol/drug use
Legal history includes current legal charges/disposition of charges

H. Treatment structure:

-Copy of completed treatment (Tx) plan, including:
    -Participant and/or parent/guardian signature, as applicable
    -Licensed personnel's signature
    -Proof initial tx plan completed within timeframe per agency policy (MH/SA)(30 days – OP/SA)

-Proof Tx plan reviews completed within 90-day (OP/SA) timeframe per agency policy

-Measurable objectives(P)

-Proof Tx plan matches assessment(P)

-Frequency and duration of activities(P)

-Individualized goals(P)

-Description of therapeutic or support method(P)

-Proof participant helped develop plan

-Indication why adjunctive services are an integral part of participant's care

-Proof Tx plan addresses both SPMI and CD disorders (Dual only)

-Proof treatment plan developed by interdisciplinary team, including participant, physician or registered nurse, participant's primary therapist, a LADC, and other appropriate program staff (Dual only)

-Prioritized measurable objectives that are time limited(P)

-Delineation of specific behavioral criteria for discharge/transition into a lower level of care

-Proof participant to therapist ratio is followed regarding group session: 12:1 (8:1 group 1:1 individual r1)(SA)

-Proof agency has at least 50% of personnel that are LADAC's (SA)

-Includes documentation justifying length of service to a participant beyond one year (exclude TC) (SA)

-Documentation requirements for day rehabilitation and for residential rehabilitation must:

-Provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided

-Provide consumer's response to those interventions.

-Documentation requirements for day rehabilitation and for residential rehabilitation/providers of multiple services must indicate how significant consumer issues are shared between providers.

I. Treatment Record:

-Date of service indicated in participant file or emergency log

-Date of service in file agrees with date in CDS

-Length of service indicated in participant file

-Length of service in file agrees with timeframe in CDS

-File documents actual length of time participant was present during partial care sessions

-Type of session indicated (individual, family, group)

-Units in CDS agree with units documented in participant file or attendance log

-Includes progress note(s) in participant record, showing:

-documentation complete & sufficient to determine content of session,

-individual's participation & progress

- Progress note(s) completed within timeframe per agency policy

-Frequency of progress notes sufficient with respect to intensity of treatment or program's/agency's policies and procedures

-Includes licensed personnel's signature, or includes a ledger located in each participant's file that includes personnel first/last name, specific program, and initials

-Consumer's opinion of progress being made (in consumer's own words, if possible)

-Tx Plan and/or Progress Note and/or Supervisor's log demonstrates supervisory sign off on all clinical entries during the first 2,000 hours of employment/PLADAC and demonstrates weekly clinical staffing of cases under either one-on-one or group supervision (SA)

-Each entry must identify the date, location of service,the first and last name and title of the staff person providing the service

-Documentation provided re: participant's need to continue Tx (ALOS is 12-18 months) (TC)
-Documentation of recovery services
-Documentation of discharge planning
-Documentation of absences or approved leaves, proof correctly claimed for reimbursement, and prevention plan (Region has an agreement with HH and TC for 5 bed hold days ((do not have to be consecutive days))
-Copy of completed discharge (D/C) summary that matches CDS discharge information
- D/C summary includes recommendations and/or arrangements not limited to:

(a) Accessing and using medication;
(b) Accessing physical health care,
(c) Employment,
(d) Transportation,
(e) Social connectedness-formal and informal support systems, and
(f) Financial resources

-D/C date in CDS agrees with date in file
-D/C summary includes personnel signature (P)
-D/C was timely per agency policy (P)
-Chart demonstrated confidentiality.

Emergency Audit List

Client files must include the following:
A. Initial treatment information:
-Copy of completed admission form, which includes:

- Proof the consumer and/or guardians, as appropriate, gave informed consent to treatment, rehabilitation and/or recovery services, medication usage and services to be provided.

-Proof that risks and benefits of every service for which consent is sought, and right to refuse service, are explained to the consumer at a level that is educationally appropriate to the individual.

-Admission date in CDS agrees with date in participant file {excluding CRT}

-Signed copy of completed attestation form (Excluding EPC and CRT)
-Proof consumer meets financial eligibility criteria (family income, number of dependents) (excluding CRT)
-Proof of appropriate referral (Social Detox, CRT)
-Proof program is available 24 hours per day, 7 days per week
- Copy of EPC certificate (EPC only)
-Copy of completed assessment, including:

-Assessment completed within timeframe per agency policy

-Assessment verifies participant meets eligibility requirements set by service definition (excluding CRT)

- Emphasis on strengths (within 72 hours for Social Detox){excluding CRT} (P)
- Assessment of needs (within 72 hours for Social Detox) {excluding CRT} (P)
-Assessment includes a SA screening and/or psychometric tool (i.e.: SASSI) (EPC, Acute, Psych Respite)
-Referral source (P), name and title of referral individual such as MD, psychologist, APRN, LIMHP
-Consumer name, Medicaid identification number, emergency contact (name, relationship, and contact information) and any other relevant consumer information

-Provider demographics including:
-provider name, address, phone, fax, e-mail and other contact information.
-Prior treatment plan(s) as appropriate and available (excluding CRT) (P)
-Clinical impressions must be completed by a licensed clinician within their scope of practice, including information that supports/justifies recommendations made and integrating mental health and substance use co-occurring disorders, as well as:

-DSM diagnosis, Axis 1-5
-Primary/ideal level of care
-Available level of care/barriers to ideal level of care
-Documentation of consumer/family's response to recommendations

-Goals that the consumer wants to accomplish
-Documentation of discharge summaries from previous levels of care in consumer record.
-Copy of proper release form(s), completed in entirety (P)
-Copy of crisis contact (CRT, Psych Respite)

B. Personal information and history:

-Employment history & strengths
-Educational history & strengths
-Military service record (DD214)
-People involved in the individual's life, including:
(1) Family members (age and level of involvement with consumer,
(2) Adult or minor children (names, ages and level of involvement), and,
(3) Other significant people and level of involvement
-Parenting knowledge or skill level, history of system involvement (courts)
-Social supports utilized by consumer (previous and current)
-Housing (ability to maintain housing, type of current housing, need for assistance)

-Recreational activities (consumer's preferences)
-Collateral information, and, consumer strengths as perceived by consumer and collateral contacts

C. Medical records

-Emergency medical information including physician contact information and the telephone number of emergency contact
-ROI is present, which allows Division, its agent, and Region to receive confidential participant information.

-Release of Information form includes one (1) year limit (excluding CRT)
-Documentation orientation was completed (excluding CRT) (P)
-Voter registration documentation (excluding CRT) (P)
-Participant rights documentation (excluding CRT) (P)
-Grievance procedures documentation (excluding CRT) (P)
-Clearly defined participant expectations (excluding CRT) (P)
-Copy of completed payment agreement form (exclude CRT), including:
-Payment agreement, including appropriate personnel, participant, and/or parent/guardian signature, as applicable (exclude Social Detox)

D. Health information

-Communication with family and friends
-Psychosocial state (P)
-Medical history, including (P):
-Current primary care physician (name and contact information)
-date of last physical exam and the physician who performed exam
-Dental history and current needs
-History of trauma (physical, emotional, mental, sexual) (P)
-List of current medications (P)
-Chronological listing of the medications prescribed (including dosages and schedule) for consumer and consumer's response to the medication
-Compliance with medication (historical and current)
-HIV screening: yes/no (P)
-TB screening: yes/no (P)
-Pregnancy screening: yes/no (P)
-IV drug use screening: yes/no (P)
-Hepatitis B screening: yes/no
-Gambling addiction screening: yes/no
-Any follow-up for positive screening of screenings above (P)

E. Psychiatric/behavioral health information:

-Current diagnosis
-Board of mental health commitments (reasons and dates of commitment)
-History of abuse (to include sexual abuse, physical abuse, emotional abuse, neglect, witness domestic violence, victim/witness of community violence, physical assault)
-History of trauma (serious accident/injury, sexual assult/rape, life-threatening medical illness, traumatic loss of a loved one, terrorist act, war/political violence/torture, disasters {tornado, earthquakes}, sanctuary trauma {trauma while institutionalized}, prostitution/sex trafficking).
-Proof psychological evaluation completed within 36 hours (EPC only)

F. Substance abuse information:

-Primary drug(s) of choice
-amount, frequency and duration of use.
-Current compliance with relapse prevention plan
-Periods of abstinence (supports needed)

-Tolerance level/withdrawal/history of complications from withdrawal
-Any prior alcohol/drug evaluations/recommendations
-Family history of alcohol/drug use
-Any other addictive behaviors
-Proof SA assessment completed and signed by licensed personnel (EPC only)

G. Legal information:

-Legal history (information from Criminal Justice System), to include criminal history and consequences of criminal involvement, including:
-Connection to alcohol/drug use
-Current legal charges/disposition of charges

H. Treatment Structure:

-Copy of completed treatment (Tx) plan, esp. information ID'd in assessment (excluding CRT):
- psychiatric emergency, community living skills and ADLS, MM, MH services, physical health care, voc/educ, SA Tx
-proof of recovery services, including crisis/relapse plan
- Each entry must identify the date, location of service, first and last name, title of the staff person providing the service.
-Participant and/or parent/guardian signature, as applicable
-Appropriate personnel's signature
-Documentation of Tx updates
-Tx plan reviews are completed within timeframe per agency policy (P)
-Measurable objectives(P)
-Proof Tx plan matches assessment(P)
-Frequency and duration of activities(P)
-Individualized goals(P)
-Description of therapeutic or support method(P)
-Proof participant helped develop plan
-Documentation requirements for day rehabilitation and for residential rehabilitation must:
-Provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided
-Provide consumer's response to those interventions
-Show how significant consumer issues are shared between providers

I. Treatment record:

-Date of service indicated in participant file or emergency log
-Date of service in file agrees with date in CDS
-Length of service indicated in participant file
-Length of service in file agrees with timeframe in CDS
-Includes progress note(s) in participant record, showing:
-documentation complete & sufficient to determine content of session,
-individual's participation & progress
- Progress note(s) completed within timeframe per agency policy
-Frequency of progress notes sufficient with respect to intensity of treatment or program's/agency's policies and procedures
-Documentation of all monitoring, observation, and medical referral activities (Social Detox), including one or more of the following:
date and time of request, specific presenting problems, involvement of other parties, action taken, and disposition of episode (Social Detox, Psych Respite, CRT)
-Recommendations for services to include referral for comprehensive SA assessment (MH) (P)
-Proof of screening for referral to an inpatient psychiatric program (Social Detox and CRT)
-Proof detoxification units claimed do not exceed five continuous days reimbursable per participant admission – unless the participant is in extended detox (Social Detox)
-Documentation of discharge planning
-Units in CDS agree with units documented in participant file or emergency log
-Consumer's opinion of progress being made (in consumer's own words, if possible)

-Service activity described fits within the service definition
-Copy of completed discharge (D/C) summary that matches CDS discharge information

-Discharge date in CDS agrees with date in participant file (excluding 24-Hr Clin/Mobile Crisis/CRT)
-Discharge form includes appropriate personnel signature (P)

-Discharge was timely per agency policy (P)
- D/C summary includes recommendations and/or arrangements not limited to:
(a) Accessing and using medication;
(b) Accessing physical health care,
(c) Employment,
(d) Transportation,
(e) Social connectedness-formal and informal support systems, and
(f) Financial resources
-Chart demonstrated
confidentiality.

Non-residential

Client files must include the following:

A. Initial treatment information:

-Copy of completed admission form in participant file

-Admission dates in claim agree with dates in file

- Documentation consumer and/or guardians gave informed consent to treatment, rehabilitation and/or recovery services, medication usage and services to be provided, as appropriate.

- Documentation of risks and benefits of every service for which consent is sought, and right to refuse service are explained to the consumer at an educationally appropriate level to individual.

-Proof consumer meets financial eligibility criteria (family income, number of dependents) (P)

-Proof of completed re-verification process every year to ensure continuing eligibility

-Proof of completed verification process upon admission to ensure participant is indigent

-Signed copy of citizen attestation.

-Copy of completed consumer assessment, including the following

-Assessment completed within timeframe per agency policy

-Assessment verifies participant meets eligibility requirements set by service definition

-Recommendations for services to include medical and/or psychological referral

-Licensed personnel signature, and, signature of fully licensed clinician approving this assessment

-Emphasis on strengths (P)

-Assessment of needs (P)

-Referral source (P), name and title of referral individual such as MD, psychologist, APRN, LIMHP

-Consumer name, Medicaid identification number, emergency contact (name, relationship, and contact information), and any other relevant consumer information.

-Prior treatment plan(s), as appropriate.

-Provider demographics including:

-provider name, address, phone, fax, e-mail and other contact information.

-Clinical impressions must be completed by a licensed clinician within their scope of practice, including information that supports/justifies recommendations made and integrating mental health and substance use co-occurring disorders, as well as:

-DSM diagnosis, Axis 1-5

-Primary/ideal level of care

-Available level of care/barriers to ideal level of care

-Documentation of consumer/family's response to recommendations

-Goals that the consumer wants to accomplish

B. Personal information and history:

-Employment history & strengths

-Educational history & strengths

-Military service record (DD214)

-People in the individual's life, including:

(1) Family members (age and level of involvement with consumer),
(2) Adult or minor children (names, ages and level of involvement), and,
(3) Other significant people and level of involvement

-Parenting knowledge or skill level, history of system involvement (courts)
-Social supports utilized by consumer (previous and current)
-Housing (ability to maintain housing, type of current housing, need for assistance)
-Recreational activities (consumer's preferences)
-Collateral information, and, consumer strengths as perceived by consumer and collateral contacts

C. Medical records:

-Emergency medical information including physician contact information and the telephone number of emergency contact
-Proper ROI form(s) completed in its entirety, including (P):
-Signature of professional, participant, and/or parent/guardian signature, as applicable
-One (1) year scope
-Documentation which allows the Division, its agent, and Region to receive confidential participant information
-Documentation that orientation was completed (P)
-Voter registration documentation (P) (include Form name?)
-Participant rights documentation (P)
-Grievance procedures documentation (P)
-Clearly defined participant expectations (P)
-Access to records
-Right to refuse Treatment
-Copy of completed payment agreement, including appropriate personnel, participant, and/or parent/guardian signature(s), as applicable

D. Health information:

-Communication with family and friends
-Psychosocial state (P)
-Medical history, including (P):
-Current primary care physician (name and contact information)
-Date of last physical exam and the physician who performed exam
-Dental history and current needs
-History of trauma (physical, emotional, mental, sexual)(P)
-List of current medications (P)
-Chronological listing of medications prescribed (including dosages and schedule) for consumer and consumer's response to the medication.
-Compliance with medication (historical and current)
-HIV screening: yes/no (P)
-TB screening: yes/no (P)
-Pregnancy screening: yes/no (P)
-IV drug use screening: yes/no (P)
-Hepatitis B screening: yes/no
-Gambling addiction screening: yes/no

-Any follow-up for positive screening of screenings above (P)

E. Psychiatric/behavioral health information:

-Current diagnosis
-Board of mental health commitments (reasons and dates of commitment)
-History of abuse (to include sexual abuse, physical abuse, emotional abuse, neglect, witness domestic violence, victim/witness of community violence, physical assault)
-History of trauma (serious accident/injury, sexual assault/rape, life-threatening medical illness, traumatic loss of a loved one, terrorist act, war/political violence/torture, disasters {tornado, earthquakes}, sanctuary trauma {trauma while institutionalized}, prostitution/sex trafficking).

F. Substance abuse information:
-Primary drug(s) of choice;
    -amount, frequency and duration of use
-Current compliance with relapse prevention plan
-Periods of abstinence (supports needed)
-Tolerance level/withdrawal/history of complications from withdrawal
-Any prior alcohol/drug evaluations/recommendations
-Family history of alcohol/drug use
-Any other addictive behaviors

G. Legal information:

-Legal history (information from Criminal Justice System) to include criminal history and consequences of criminal involvement, including:
    -Connection to alcohol/drug use
    -Current legal charges/disposition of charges

H. Treatment structure:

-Copy of completed treatment (Tx) plan, including:
    -Participant and/or parent/guardian signature, as applicable
    -Appropriate and/or licensed personnel's signature, as needed
    -Proof initial Tx plan completed within timeframe per agency policy (MH/SA)(30 days – OP/SA)
    -Proof Tx plan reviews completed within 90-day (OP/SA) timeframe per agency policy
    -Measurable objectives(P)
    -Proof Tx plan matches assessment(P)
    -Frequency and duration of activities(P)
    -Individualized goals(P)
    -Description of therapeutic or support method(P)
    -Proof participant helped develop plan
    -Indication why adjunctive services are an integral part of participant's care
    -Proof Tx plan addresses both SPMI and CD disorders (Dual only)

-Crisis/Relapse Prevention, (SPMI & CD/SA)
-Proof treatment plan developed by interdisciplinary team, including participant, physician or registered nurse, participant's primary therapist, a LADC, and other appropriate program staff (Dual only)
-Prioritized measurable objectives that are time limited(P)
-Delineation of specific behavioral criteria for discharge/transition into a lower level of care
-Recommendations for referral to other services, as appropriate (P)

-Proof participant to therapist ratio is followed regarding group session: 12:1 (SA)
-Proof agency has at least 50% of personnel that are LADAC's/PLADAC's (SA)
-Includes rationale for the expected frequency and duration of "drug holidays" (MM only)

-Includes documentation justifying length of service to a participant beyond one year (SA)
-Documentation requirements for day rehabilitation and for residential rehabilitation must:
-Provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided
-Provide consumer's response to those interventions.
-Documentation requirements for day rehabilitation and for residential rehabilitation/providers of multiple services must indicate how significant consumer issues are shared between providers.

I. Treatment Record:

-Date of service indicated in participant file or emergency log
-Date of service in file agrees with date in CDS
-Length of service indicated in participant file
-Length of service in file agrees with timeframe in CDS
-Type of session indicated (individual, family, group)
-Units in CDS agree with units documented in participant file or attendance log
-Includes progress note(s) in participant record, showing:
-documentation complete & sufficient to determine content of session,
-individual's participation & progress
- Progress note(s) completed within timeframe per agency policy
-Frequency of progress notes sufficient with respect to intensity of treatment or program's/agency's policies and procedures
-Includes licensed personnel's signature, or includes a ledger located in each participant's file that includes personnel first/last name, specific program, and initials
-Includes documentation from physician that includes discontinuation, the date and reason each drug is discontinued (MM only)
-Consumer's opinion of progress being made (in consumer's own words, if possible)
-Tx Plan and/or Progress Notes and/or Supervisor's Log includes licensed personnel's signature and is indicative of weekly clinical staffing of cases under either one-on-one or group supervision (SA)
-Proof telephone contact was documented as therapeutic, billed and/or billing state available (Dual only)
-Proof Service activity described fits within the service definition
-Documentation of recovery services

- Each entry must identify the date, location of service, the first and last name, title of the staff person providing the service.

-Documentation of discharge planning
-Documentation of discharge summaries from previous levels of care
-Copy of completed discharge (D/C) summary that matches CDS discharge information
-Proof Consumer has not received services for 90 days or more
-D/C summary includes summary of service provided
- D/C summary includes recommendations and/or arrangements not limited to:
(a) Accessing and using medication;
(b) Accessing physical health care,
(c) Employment,
(d) Transportation,
(e) Social connectedness-formal and informal support systems, and
(f) Financial resources
-D/C date in CDS agrees with date in file
-D/C summary includes personnel signature (P)
-D/C was timely per agency policy (P)

Appendix D -Psychosocial Audit List

Client files must include the following:

A. Initial treatment information:

-Copy of completed admission form in participant file
-Admission dates in CDS agree with dates in file
- Documentation consumer and/or guardians gave informed consent to treatment, rehabilitation and/or recovery services, medication usage and services to be provided, as appropriate
- Documentation of risks and benefits of every service for which consent is sought, and right to refuse service are explained to the consumer at an educationally appropriate level to individual.
-Proof consumer meets financial eligibility criteria (family income, number of dependents) (P)
-Proof of completed re-verification process every year to ensure continuing eligibility
-Proof consumer meets eligibility requirements based on service definition
-Signed copy of citizen attestation
-Documentation orientation was completed
-Documentation that no other concurrent claims exist in another service modality
-Copy of completed consumer assessment, including the following
-Assessment completed within timeframe per agency policy
-Assessment verifies participant meets eligibility requirements set by service definition
-Recommendations for services to include medical and/or psychological referral
-Mechanism to refer consumers for comprehensive SA assessment (MH)
-SA screening and/or psychometric tool (i.e. SASSI) (MH)
-Appropriate personnel signature, and signature of fully licensed clinician approving this assessment

-Assessment of strengths and needs (P)
-Referral source (P), name and title of referral individual such as MD, psychologist, APRN, LIMHP
-Consumer name, Medicaid identification number, emergency contact (name, relationship, and contact information), and any other relevant consumer information.

-Provider demographics including:
-provider name, address, phone, fax, e-mail and other contact information.

-Clinical impressions must be completed by a licensed clinician within their scope of practice, including information that supports/justifies recommendations made and integrating mental health and substance use co-occurring disorders, as well as:
-DSM diagnosis, Axis 1-5
-Primary/ideal level of care
-Available level of care/barriers to ideal level of care
-Documentation of consumer/family's response to recommendations
-Goals that the consumer wants to accomplish

-Copy of assessments from other providers

B. Personal information and history:

-Employment history & strengths
-Educational history & strengths
-Military service record (DD214)
-People in the individual's life, including:
(1) Family members (age and level of involvement with consumer),
(2) Adult or minor children (names, ages and level of involvement), and,
(3) Other significant people and level of involvement

-Parenting knowledge or skill level, history of system involvement (courts)
-Social supports utilized by consumer (previous and current)
-Housing (ability to maintain housing, type of current housing, need for assistance)
-Recreational activities (consumer's preferences)
-Collateral information, and, consumer strengths as perceived by consumer and collateral contacts

C. Medical records:

-Emergency medical information including physician contact information and the telephone number of emergency contact
-Proper ROI form(s) completed in its entirety, including (P):
-Signature of professional, participant, and/or parent/guardian signature, as applicable
-One (1) year scope
-Documentation which allows the Division, its agent, and Region to receive confidential participant information

-Documentation that orientation was completed (P)
-Voter registration documentation (P) (include Form name?)
-Participant rights documentation (P)
-Grievance procedures documentation (P)
-Clearly defined participant expectations (P)

-Access to records
-Right to refuse Treatment
-Copy of completed payment agreement, including appropriate personnel, participant, and/or parent/guardian signature(s), as applicable

D. Health information:
-Communication with family and friends
-Medical history, including (P):
    -Current primary care physician (name and contact information)
    -Date of last physical exam and the physician who performed exam
    -Dental history and current needs
-History of trauma (physical, emotional, mental, sexual)(P)
-List of current medications (P)
-Chronological listing of medications prescribed (including dosages and schedule) for consumer and consumer's response to the medication.
-Compliance with medication (historical and current)
-HIV screening: yes/no (P)
-TB screening: yes/no (P)
-Pregnancy screening: yes/no (P)
-IV drug use screening: yes/no (P)
-Hepatitis B screening: yes/no
-Gambling addiction screening: yes/no
-Any follow-up for positive screening of screenings above (P)

E. Psychiatric/behavioral health information:

-Current diagnosis
-Board of mental health commitments (reasons and dates of commitment)
-History of abuse (to include sexual abuse, physical abuse, emotional abuse, neglect, witness domestic violence, victim/witness of community violence, physical assault)
-History of trauma (serious accident/injury, sexual assault/rape, life-threatening medical illness, traumatic loss of a loved one, terrorist act, war/political violence/torture, disasters {tornado, earthquakes}, sanctuary trauma {trauma while institutionalized}, prostitution/sex trafficking).

F. Substance abuse information:
-Primary drug(s) of choice;
    -amount, frequency and duration of use
-Current compliance with relapse prevention plan
-Periods of abstinence (supports needed)
-Tolerance level/withdrawal/history of complications from withdrawal
-Any prior alcohol/drug evaluations/recommendations
-Family history of alcohol/drug use
-Any other addictive behaviors

G. Legal information:

-Legal history (information from Criminal Justice System) to include criminal history and consequences of criminal involvement, including:

-Connection to alcohol/drug use
-Current legal charges/disposition of charges

H. Treatment structure:

-Copy of completed treatment (Tx) plan, including:
-Participant and/or parent/guardian signature, as applicable (MH)
-Appropriate and/or licensed personnel's signature, as needed
-Proof initial Tx plan completed within timeframe per agency policy (MH/SA)(30 days – OP/SA)
-Proof Tx plan reviews completed within 90-day (OP/SA) timeframe per agency policy
-Measurable objectives(P)
-Proof Tx plan matches assessment(P)
-Frequency and duration of activities(P)
-Individualized goals(P)
-Description of therapeutic or support method(P)
-Proof participant helped develop plan
-Indication why adjunctive services are an integral part of participant's care
-Proof Tx plan addresses both SPMI and CD disorders (Dual only)
-Crisis/Relapse Prevention, (SPMI & CD/SA)
-Proof treatment plan developed by interdisciplinary team, including participant, physician or registered nurse, participant's primary therapist, a LADC, and other appropriate program staff (Dual only)
-Prioritized measurable objectives that are time limited(P)
-Delineation of specific behavioral criteria for discharge/transition into a lower level of care
-Recommendations for referral to other services, as appropriate (P)
-Copy of completed integrated Tx that addresses one or more of the following, as applicable:
-Community living skills
-ADLS
-Interpersonal skills
-Psychiatric emergency/relapse
-MM
-Mental health services
-Physical healthcare
-Vocational/educational services
-Substance abuse services
-resource acquisition
-Proof participant to therapist ratio is followed regarding group session: 12:1 (SA)
-Proof agency has at least 50% of personnel that are LADAC's/PLADAC's (SA)
-Includes documentation justifying length of service to a participant service definition
-Documentation requirements for day rehabilitation and for residential rehabilitation must:
-Provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided
-Provide consumer's response to those interventions.

-Documentation requirements for day rehabilitation and for residential rehabilitation/providers of multiple services must indicate how significant consumer issues are shared between providers.

I. Treatment Record:

-Date of service indicated in participant file or emergency log
    -Date of service in file agrees with date in CDS
-Length of service indicated in participant file
    -Length of service in file agrees with timeframe in CDS
-Type of session indicated (individual, family, group)
-Units in CDS agree with units documented in participant file or attendance log
-Includes progress note(s) in participant record, showing:
    -documentation complete & sufficient to determine nature/content of services,
    -individual's participation & progress
    - Progress note(s) completed within timeframe per agency policy
    -Frequency of progress notes sufficient with respect to intensity of Tx or program's/agency's policies and procedures
-Includes licensed personnel's signature, or includes a ledger located in each participant's file that includes personnel first/last name, specific program, and initials
- Documentation of absences or approved leaves and proof correctly claimed for reimbursement
-Consumer's opinion of progress being made (in consumer's own words, if possible)
-Tx Plan and/or Progress Notes and/or Supervisor's Log shows supervisory sign off on all clinical entries and shows clinical staffing of casus under either one-on-one or group supervision
-Proof service activity described fits within the service definition
-Documentation of recovery services
    - Each entry must identify the date, location of service, the first and last name, title of the staff person providing the service.
-Documentation of discharge planning
-Documentation of discharge summaries from previous levels of care
-Copy of completed discharge (D/C) summary that matches CDS discharge information
-Proof Consumer has not received services for 90 days or more (MH)
-D/C summary includes summary of service provided
- D/C summary includes recommendations and/or arrangements not limited to:
    (a) Accessing and using medication;
    (b) Accessing physical health care,
    (c) Employment,
    (d) Transportation,
    (e) Social connectedness-formal and informal support systems, and
    (f) Financial resources
-D/C date in CDS agrees with date in file
-D/C summary includes appropriate personnel signature (P)
-D/C was timely per agency policy (P)
-Chart demonstrated confidentiality