CONFIDENTIAL CHART REVIEW SUMMARY

Specialty Mental Health Services

Organization Name	Program Name	Billing Review Period		
			to	

Client #	Medical Record #	Date of Birth	Insurance	Reviewer

Items in **Bold are requirements identified by DHCS as reasons for recoupment if not compliant and/or in certain conditions.**

REQ #	ASSESSMENTS	RESULT	FINDING
A1	Was the individual's assessment completed within a reasonable time and in accordance with generally accepted standards of practice? This includes a typed or legibly printed name, signature of the service provider and date of signature.		
A2	Does the assessment include all 7 domains?		
A2a	Domain 1: Presenting Problem(s), Current Mental Status, History of Presenting Problem(s) and Beneficiary-Identified Impairment(s)		
A2b	Domain 2: Trauma		
A2c	Domain 3: Behavioral Health History, Comorbidity		
A2d	Domain 4: Medical History, Current Medications, Comorbidity with Behavioral Health		
A2e	Domain 5: Social and Life Circumstances, Culture/Religion/Spirituality		
A2f	Domain 6: Strengths, Risk Behaviors and Safety Factors		
A2g	Domain 7: Clinical Summary and Recommendations, Diagnostic Impression, Medical Necessity Determination/Level of Care/Access Criteria		
A3	Are all applicable diagnoses, including any substance use disorders, present and consistent with the information noted in the assessment?		
A4	**Does the clinical record substantiate the beneficiary's need for Specialty Mental Health Services (SMHS) [Medical Necessity; Criteria for beneficiary access to SMHS] as appropriate to their age? If no, identify the services in the Services Addendum.** *BHIN 21-073*		
Assessment Comments (if none, enter "N/A"):			

REQ #	PROBLEM LIST	RESULT	FINDING
PL1	Is there a problem list present in the chart that includes all required elements?		
PL2	Is the name and title present of each provider that identified, added or removed items from the problem list as well as the date the items were identified, added or removed?		
PL3	Has the problem list been updated on an ongoing basis to reflect the current presentation of the beneficiary and within a reasonable time and in accordance with generally accepted standards of practice?		
PL4	Does the problem list reflect the current client needs, including any identified diagnoses, social determinants of health and/or Z codes and has the problem list been updated any time there is a relevant change to the beneficiary's condition?		

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Problem List Comments (if none, enter "N/A"):

REQ #	PROGRESS NOTES	RESULT	FINDING
PN1	Were the majority of progress notes finalized within 3 business days (with the exception of progress notes for crisis services, which shall be completed within 24 hours)?		
PN2	**Are progress notes signed (or the electronic equivalent) by the person providing the service? If no, identify the claims in the Services Addendum.** *MHP Contract; BHIN 22-019*		
PN3	Do all progress notes include the legible name of the provider, the date of signature, interventions provided and next steps to be taken by provider (i.e., plan)?		
PN4	Do progress notes include a sufficient description of specialty mental health intervention(s) provided?		
PN5	For clients with identified risks, do progress notes document ongoing assessment, clinical monitoring, and intervention(s) that relate to the level of risk, when appropriate?		
PN6	For clients diagnosed with a co-occurring substance use disorder, do progress notes document specific integrated mental health treatment approaches, when appropriate?		
PN7	If necessary, were relevant substance use disorder (SUD) treatment referrals provided and documented in a progress note?		
PN8	For clients with physical health needs related to their mental health treatment, do progress notes document that physical health care is integrated into treatment through education, resources, referrals, symptom management and/or care coordination with physical healthcare providers?		
PN9	Are any gaps in service delivery supported by non-billable notes or explained elsewhere in the clinical record?		
PN10	Does the chart as a whole include evidence of care coordination across providers, agencies, county systems (e.g. child welfare and Behavioral Health (BH)), significant support person(s) and/or between delivery systems (Managed Care Plan (MCP) and Mental Health Plan (MHP))?		
PN11	Based on the documentation as a whole, is there evidence that treatment is high quality, person centered, culturally responsive and aligned with client needs?		
PN12	Have all risk and safety issues in the client record been addressed?		

Progress Notes Comments (if none, enter "N/A"):

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REQ #	OTHER DOCUMENTATION	RESULT	FINDING
OD1	Is there evidence of informed consent in the client record?		
OD2	If telehealth or telephone services are provided, is there documented consent (written or verbal) specific to the provision of telehealth services prior to initial delivery of services?		
OD3	Are all required beneficiary intake materials present in the client record?		
OD4	For clients whose primary language is something other than English, is there evidence of informing materials provided to client in primary language or documented evidence that informing materials were explained to client in primary language with acknowledgement of understanding?		
OD5	Are outcome measures (e.g., Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptoms Checklist 35 (PSC-35) completed as required (if applicable)?		
OD6	Do the MHP records include a copy of the client's Screening Tool, if applicable?		
OD7	Do the MHP records include a copy of the client's Transition of Care Tool, if applicable?		

Other Documentation Comments (if none, enter "N/A"):

REQ #	SPECIALIZED SERVICES	RESULT	FINDING
SS1	If client receives TCM, is there a completed care plan documented within the client record?		
SS2	If client receives Peer Support Services (PSS) services from a Certified Peer Support Specialist, is there a completed care plan documented within the client record?		
SS3	If client receives Therapeutic Behavioral Services (TBS), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC), and/or Intensive Care Coordination (ICC), is there a completed care plan documented within the client record?		
SS4	If client has an open Child Welfare Services (CWS) case, has eligibility and authorization for ICC and/or IHBS been established?		
SS5	If receiving ICC and/or IHBS services, does the client record contain documentation that a Child and Family Team (CFT) meeting has occurred within 30 days of intake and at a minimum of every 90 days thereafter? **If CFT meeting timelines are not met, does chart include documentation of reasons for postponement and efforts to reschedule CFT meetings?		

Specialized Services Comments (if none, enter "N/A"):

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REQ #	**BILLING**			**RESULT**	**FINDING**
B1	**Is there any evidence of fraud, waste, or abuse? If yes, identify the claims in the Services Addendum.**				
B2	**Were any services provided while the client was in a Medi-Cal lock-out place of service (e.g., psych hospitalization, Institution for Mental Disease (IMD) juvenile hall*, jail)? If yes, identify the services in the Services Addendum.** **Note: For dependent minors in juvenile detention, Medi-Cal services can be provided prior to disposition, if there is a plan to make the minor's stay temporary (CCR, title 22, section 50273(c)(5)) and after adjudication for release into community (CCR, title 22, section 50273(c)(1)).** *CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.3601840.374; Code of Federal Regulations (CFR), title 42, part 435, sections 435.1008 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d, Code of Federal Regulations, title 42, sections 435.1009 – 435.1010; CCR, title 22, section 50273(a)(5-8), (c)(1, 5); title 22, section 51458.1(a)(8).*				
B3	**Is there documentation of a valid allowable service for every claim billed within the review period? If no, identify the claims in the Services Addendum.** *CCR, title 9, section 1840.112(b)(3); BHIN 22-019; MHP Contract, Exhibit E, Attachment 1); CCR, title 22, section 51458.1(a)(3)(7).*				
B4	**Does the date of service listed on the progress notes match the date of service listed on all claims? If no, identify the claims in the Services Addendum.** ***Recoupment is limited to examples where the program is unable to provide other documented evidence that the progress note with the "mismatched" date actually corresponds to the claim in question, and/or was due to a clerical error.** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).*				
B5	**For all progress notes, did the service that was claimed (procedure code) match the service documented in the progress note? If no, identify the claims in the Services Addendum.** ***Results in recoupment only when there is an overbilling** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).*				
B6	**Do all units of time for services match the amount of time documented in the progress note? If no, identify the claims in the Services Addendum.** ***Recoupment is limited to mismatches that result in overbilling.** CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c); MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).*				

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B7	Do all progress notes include required elements (date of service, service type, person contacted, location of service, contact type, evidence based practice (EBP), appointment type)?				
B8	**Do individual and/or group progress notes with multiple providers clearly identify the number of providers and the specific involvement and interventions of each provider? If no, identify the claims in the Services Addendum.** *CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5; CCR, title 22, section 51458.1(a)(3).*				
B9	**Are all documented services within the scope of practice of the provider? If no, identify the claims in the Services Addendum.** *CCR, title 9, section 1840.314(d); BHIN 22-019*				
B10	**Do group progress notes identify the total number of beneficiaries participating in the service activity? If no, identify the claims in the Services Addendum.** *CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5; CCR, title 22, section 51458.1(a)(3).*				
B11	**For group progress notes, was the claim properly apportioned to all clients present? If no, identify the claims in the Services Addendum.** ***Recoupment limited to apportionments that resulted in overbilling.** CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; CCR, title 22, section 51458.1(a)(3).*				
B12	**Were all services billable according to Title 9; with no services claimed that were solely academic, vocational, recreation, socialization, transportation, clerical or payee related? If no, identify the claims in the Services Addendum.** *CCR, title 9, sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), 1840.312(a-f) CCR, title 22, section 51458.1(a)(7).*				
Billing Comments (if none, enter "N/A"):					