County of Fresno

DEPARTMENT OF BEHAVIORAL HEALTH
SUSAN L. HOLT, LMFT
DIRECTOR / PUBLIC GUARDIAN

Date: **[Date]**

Provider
Street Address
City State, Zip

Dear **[Provider Name]**,

Please be informed that on **[Date]** through **[Date]** at **[Time]** the DBH Managed Care-Substance Use Disorder Services will perform a site review. The purpose of the review is to examine program records and ensure adherence to Federal, State, and County standards.

The date range for this audit is **[Date]** through **[Date]**. Please provide an adequate and confidential working area to conduct the review. There will be a minimum of 2 staff from Managed Care attending this review.

Below is the list of beneficiaries for review:

Beneficiary Name	**Avatar Number**	**Beneficiary Name**	**Avatar Number**

The review will consist of all beneficiary files identified, **all** personnel files (including volunteers, interns and the medical director) for everyone who worked during the audit period as well as current personnel, a review of your policies and procedures, a facility walkthrough, group observation and a review of medication logs (if applicable).

Any claimed service without supporting documentation noted during the review will be automatically disallowed unless you are able to provide the missing documentation on the day of the review while the reviewers are on-site.

In connection with the audit, you must provide all supporting documentation relevant to services provided during the audit period, including but not limited to intake and admission documentation, assessments, establishment of medical necessity, treatment plans, progress notes and sign-in sheets.

The attached Provider Staff Information Form will need to be completed and returned to **[Audit Lead Role]** via email by **[Date]**. Additionally, **please include a schedule of all group sessions** from **[Date]** through **[Date]**.

You will receive a summary of the results after the review is completed. If there are programmatic deficiencies identified, you will be required to correct and demonstrate correction of any issues within the specified timeline in accordance with 22 CCR §51341.1 (o)(1)(2)(3).

Additionally, in accordance with Title 42, CFR, Section 455.1 (a) (2), a Verification of Services (VOS) letter will be sent to the above listed clients, which will indicate the service dates, description, and provider so the client may review and contact the Compliance Unit if they find the information is inaccurate or untrue. The Compliance Unit will review client responses to these annual VOS mailings and will take appropriate action if the services were not received by the client.

Here is an excerpt of the Verification of Services letter:

…. We have attached a sheet that shows our record of the treatment services you have recently received. We are hoping that you will take a few minutes of your time and review the dates, description of service, and the treatment provider to determine if this information is accurate. If you did not receive these services, please call the ***Compliance Unit at 1-888-262-4174.***

Clients Under Minor Consent: For client records listed above for review, please notify us if any of the clients are under minor consent so that the VOS letter is mailed appropriately. Contact the Staff Analyst by email at [Email] no later than [Date]. Your notification regarding client minor consent status is imperative in order to avoid a potential HIPAA privacy breach.

Thank you for your cooperation and continued participation with Fresno County Department of Behavioral Health Managed Care Division-Substance Use Disorder Services.

If you have any questions please feel free to contact **[Audit Lead Role]** at **[Phone Number]**.

Sincerely,

[Name, License]/dc
Clinical Supervisor
Managed Care-Substance Use Disorder Services
Department of Behavioral Health
1925 E Dakota Avenue
Fresno, CA 93726

Cc: **[Name]**, Division Manager - Managed Care, Department of Behavioral Health