NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Division of Behavioral Health Audit Manual

Final March 1, 2020

***Please note the DBH had an operational excellence project and the fiscal expense verification section will change as a result of this project.**

TABLE OF CONTENTS

TABLE OF CONTENTS 2

PART I: OVERSIGHT FUNCTIONS 3

PART II: SCHEDULE OF AUDITS FOR CURRENT FISCAL YEAR 6

PART III: CPA AUDIT 7

A. CPA Audit Flowchart 9

PART IV: GENERAL VERIFICATION/REVIEW PROCEDURES 10

PART V: SERVICES PURCHASED VERIFICATIONS (UNIT/EXPENSE) 12

A. Services Purchased Verification Decision Flowchart 17

B. Non Fee for Services Verification Decision Flowchart 18

PART VI: PROGRAM FIDELITY REVIEWS 19

PART VII: DBH REQUIRED RESISTRATION AND AUTHORIZATION 21

APPENDIX A: MEDICAL AND THERAPEUTIC LEAVE 22

APPENDIX B: MANDATORY REVIEW COMPONENTS TO BE INCLUDED UPON REVIEW OF FILES OR NATIONAL ACCREDITATION REPORT 23

APPENDIX C: SUPPORTED EMPLOYMENT REVIEWS 38

PART I:
Oversight Functions

The Division of Behavioral Health (DBH) and the Regional Behavioral Health Authority (RBHA) monitors, reviews, and perform programmatic, administrative, quality improvement, fiscal accountability and oversight functions on a regular basis with all subcontractors. 71-806.

The DBH and RBHA use internal and external measures for oversight of services purchased (unit/expense) through the contracts with their subcontractors.

External measures are performed by entities outside of the DBH, and include as appropriate:

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

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

2. National Accreditation:

    a. National Accreditation refers to the standards set by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or other nationally recognized accreditation organization approved by the Director of DBH 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 or service

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

1. Services Purchased Verifications (unit/expense)

    a. The Services Purchased (SP) Verifications (unit/expense) 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 and expense verifications for services considered as non-fee for service may be completed no later than October 31 following the fiscal year under review.

    b. SP verification of services purchased (unit/expense) includes a review of any documentation to verify that the services purchased (unit/expense) were delivered consistent with set requirements. This can include clinical records, progress notes, financial records, and/or other documentation as deemed necessary. Services purchased verifications (unit/expense) shall be conducted on a fiscal year basis for all services billed to the RBHA and to the DBH under the contract as reflected by Authorization Turn-Around Documents (TADs) or other DBH required supporting documentation. SP verifications (unit/expense) 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.

2. Program Fidelity Reviews (programmatic)

    a. 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 for each provider and for each service type. National accreditation may preclude the review of certain surveyed items as determined by the reviewer.

3. Internal Controls (self-review & monitoring)

   a. Each subcontractor 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.
      i. In compliance with the COSO (Committee of Sponsoring Organizations) documents:
         a. Standards for Internal Control in Federal Government
         b. Internal Control Integrated Framework
      ii. The websites for COSO and the COSO Internal Control documents are:
         a. https://www.coso.org/Pages/default.aspx
         b. https://www.coso.org/Pages/ic.aspx
      iii. 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:
         a. Council on Financial Assistance Reform: https://cfo.gov/cofar/
         b. National Council of Nonprofits: https://www.councilofnonprofits.org/
   b. 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.
   c. 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.
   d. 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.

4. Financial Reliability of Sub-recipients

   a. 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
      i. Pre-award and ongoing
         a. Required use of a form or checklist for risk assessment
         b. Sub-recipient required to relate financial data to performance accomplishments of the Federal Award
      ii. Audit findings – systematic review and follow-up
      iii. Written policies
         a. Cash management
         b. Allowable costs-in accordance with cost principles (2 CFR 200).

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

   a. 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 with substance use disorders (IV drug users, pregnant women, women with dependent children). This fidelity review is conducted a minimum of once every three years for each subcontractor for each

service which is funded by SAPTBG funds and is conducted at the time of the services purchased review.

The written procedures outlined in this document provide a systematic approach (across all RBHAs and the DBH) to the oversight of network management, including the monitoring and reviewing of contracted services (unit/expense). Each RBHA is charged with developing Regional written policies and procedures, consistent with the components outlined in this manual, for use in the review of services purchased (unit/expense) from all subcontracted entities. RBHAs shall include, at a minimum, all of the components included in the most recently DBH Audit Manual in their written procedures. Any changes made to the DBH manual should be reflected in the RBHA's written procedures and shall be submitted to the DBH. Unless otherwise agreed upon or required, the DBH will use the RBHA's procedures and review forms when conducting reviews of RBHA-provided services for Services Purchased (unit/expense) 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, whenever possible. RBHAs will be notified in writing 30 business days prior to the effective date of any change.

All consumers must be assessed for their ability to pay for services received in accordance with the provider policy as approved by the RBHA, and through use of the approved format.

PART II:
Schedule of Audits for Current Fiscal Year

A list of the verifications or reviews to be performed is submitted to the DBH by the RBHA for the upcoming fiscal year. As services are added or removed, the RBHA must provide the DBH notification of the change and an updated verification or review list. 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 RBHA by location and services provided in each location.
- If there is a service or provider to be added/deleted/changed the appropriate forms need to be completed and sent to the DHHS.DBHNetworkOperations@nebraska.gov.
- RP-2a (Services Purchased Verification (unit/expense) & Program Fidelity Review List): this form is submitted with the RBP and lists all services within the RBHA to be audited by the RBHA. The RBHA 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 (unit/expense) must be conducted each fiscal year. Each service listed on the form will have a services purchased review (unit/expense) for each 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 RBHA/DBH chooses.

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

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

When scheduling audits, the DBH and RBHAs 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.

PART III:
CPA Audit

CPA audits are required of all RBHAs and some service providers every year. CPA audits of the RBHA are due to the DBH 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 RBHA not more than nine (9) months after the end of the service provider's fiscal year, as reflected by the RBHA on the RP-2.

The RBHA shall complete a review of each service provider financial audit by a CPA firm. Documentation of the RBHA's review and comments shall be made available to the DBH 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 RBHA
- A cover sheet signed by RBHA staff reviewing with any material weaknesses and significant deficiencies identified, implications for findings, and other activity detailing RBHA oversight;

If material weaknesses or significant deficiencies are found by the CPA firm, a corrective action plan will be requested by the RBHA. The RBHA 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:
- 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 system 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 it relates to the financial close and reporting process to ensure that accounts are properly stated throughout 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 RBHA 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

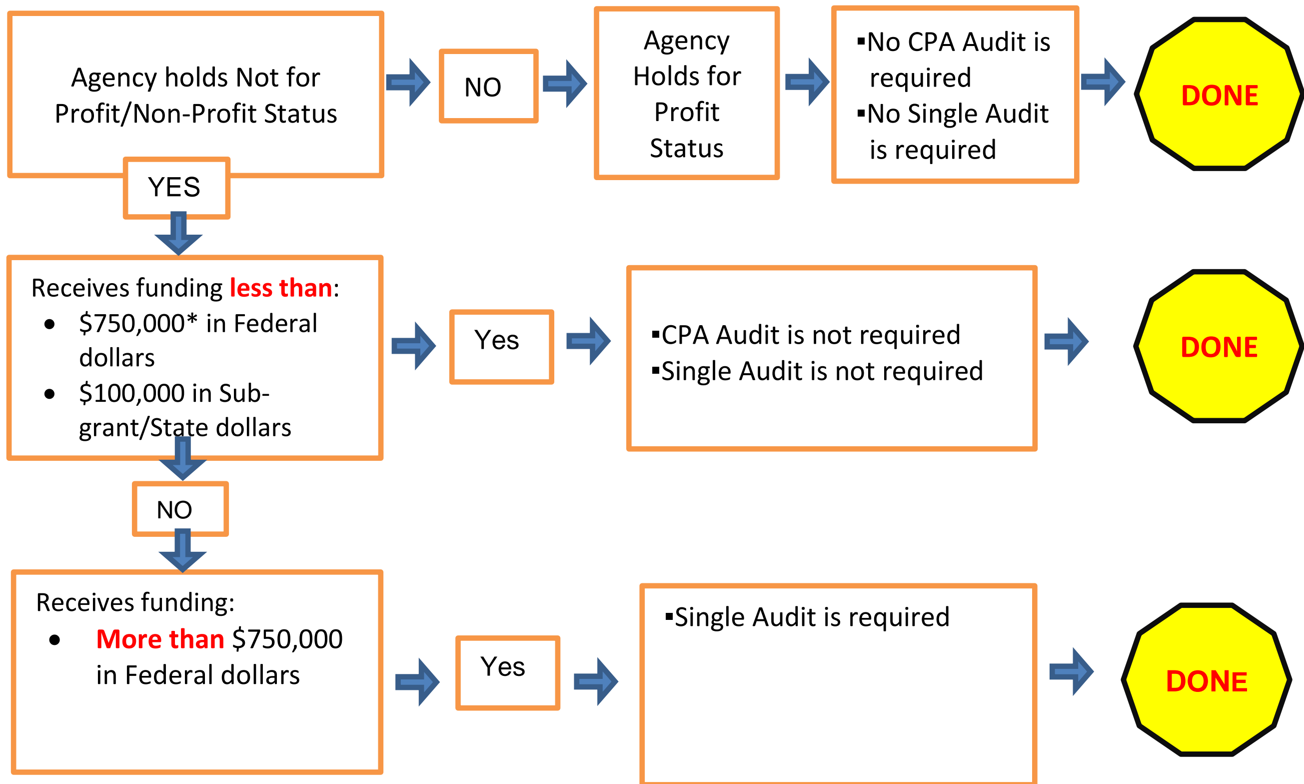
CPA audits of the RBHA must include a two-year comparison of expenditures.

Expenditure Threshold under the Single Audit Act

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. 8 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.

PART IV:
General Verification/Review Procedures

The following procedures apply to both the Services Purchased Verification (unit/expense) and the Program Fidelity Review.

Pre-Visit

All network providers should receive reviewer specific policies and procedures, which includes purpose, methods and process for Program Fidelity Reviews and Services Purchased Verifications (unit/expense).

The reviewer will work with the provider agency to establish the review date. The reviewer 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 reviewer team at the appointed time and location.

The reviewer 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

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. Review 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 team members may want to reference the Confidentiality Authority to review/verify files.

The Review Process

A room or work area, including computer access if necessary, should be made available for the review team members to review confidential records.

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 (unit/expense) and program fidelity review standards and procedures.

Out of Region Network Providers

RBHA who have letters of agreement (LOA) with a provider in another region may choose to audit the provider directly, or asks the contracted RBHA to conduct the audit. If the contracted RBHA audits for the RBHA with LOAs, they will include the consumers with the LOAs in their random sample pull. The contracted RBHA will share reviews/verifications as well as the CPA audit (if one is required) with the RBHA with LOA's. The RBHA who holds the LOA should provide information to the contracted RBHA in a timely manner. Sample sizes should be based upon all contracted and LOA units. Additionally, if the RBHA with the LOAs verifies the consumer's units and information, then that RBHA should notify the contracted RBHA.

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) business days of the visit. There should be one report per provider agency, but each service will be addressed separately within the report. Copies of the report will be sent into the DBH.

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

Audit report summarizing the Services Purchased Verification (unit/expense) and Program Fidelity Review findings per agency provider shall be given to the reviewers governing body every fiscal year.

Service Provider Challenges to Services Purchased (unit/expense) and Program Fidelity Audit Findings

For challenges that are Regulations based, refer to Nebraska Administrative Code (NAC) Title 206: Behavioral Health Services

The process for challenges that are contract based is outlined below:

For Service Providers reviewed by RBHA personnel, follow the RBHA's grievance process and timelines.

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

1. Within 10 business days of the Services Purchased (unit/expense) and 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 DBH Director, or designee, will acknowledge, in writing, the Service Provider's request for review.
3. The DBH Director serves as the decision maker for this process and will issue a written decision to the Service Provider within 20 business 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.

PART V:
Services Purchased Verifications (Unit/Expense)

All services purchased (unit/expense) must be verified on a fiscal year basis regardless if they are paid by the RBHA on a fee for service (FFS) determined rate or as non-fee for service (NFFS) expense reimbursement.

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

Services Purchased Verifications (unit/expense) may be conducted together or separately. The deadline for completion of Services Purchased Verifications (unit/expense) is October 31st following the fiscal year being reviewed in order to allow a more thorough review of June services (unit/expense).

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 reviewer including the Turn-Around Document (TAD), or other DBH required documentation for authorized or registered encounter units submitted with provider billings of the current fiscal year.

At a minimum, the verification must review a random selection of two percent (2%) of the total number of 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. Consumer is ineligible according to the DBH Financial Eligibility, including Citizen Attestation, and Fee Schedule or when there was no current Financial Eligibility determination on file at the time of the service provision (Current defined as within the 11 months prior to the month of the service);
d. Service provision is found to have been provided by an individual without the appropriate licensure as defined by DBH/reviewer service definitions.

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

The reviewers should trace payment back to ensure any retro eligible units were not charged to the reviewer within the fiscal year.

If a service provider scores less than a 95% compliance rate, the 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.

The reviewer should verify that when a provider is billing for someone with insurance and the claim was denied, the provider is billing the reviewer within 30 business days of the date of insurance denial. If the denial is due to the provider not filing in a timely manner, DBH will not reimburse.

Post Review and Reporting

Components of the review report shall include:

- Name of agency and service(s) 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.

The reviewer has 45 business 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 reviewer within 30 business days of the time of receipt of the audit summary. In all instances, service providers will be given a reasonable length of time (30 business 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 reviewer shall withhold payment from the service provider for the identified service(s) until such required documentation is received by the reviewer. The reviewer may also choose to terminate their contract with the provider if the provider shows no effort in taking corrective action.

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 an approved CAP. The re-audit shall consist of 5% or a minimum of 5 files of state fiscal year total units contracted, and units shall be drawn from the months since the CAP was submitted. If the provider does not have 5 files to re-audit the reviewer may choose to wait until 5 files are available.

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

Medical and Therapeutic Leave Sample

RBHAs must 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 reviewer's 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 reviewer,
- 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 reviews 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 reviewer. This will include verifying that any revenue received/generated by the service provider was deducted from the total expense and the adjusted expense amount was billed to the reviewer.

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 by the reviewer 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 reviewer (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 $1/12^{th}$ 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 corresponding refund 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 audit 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 reviewer 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 DBH upon request. A copy of the report shall be shared with other advisory or governing bodies.

Final reports shall be written within 45 business days 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:

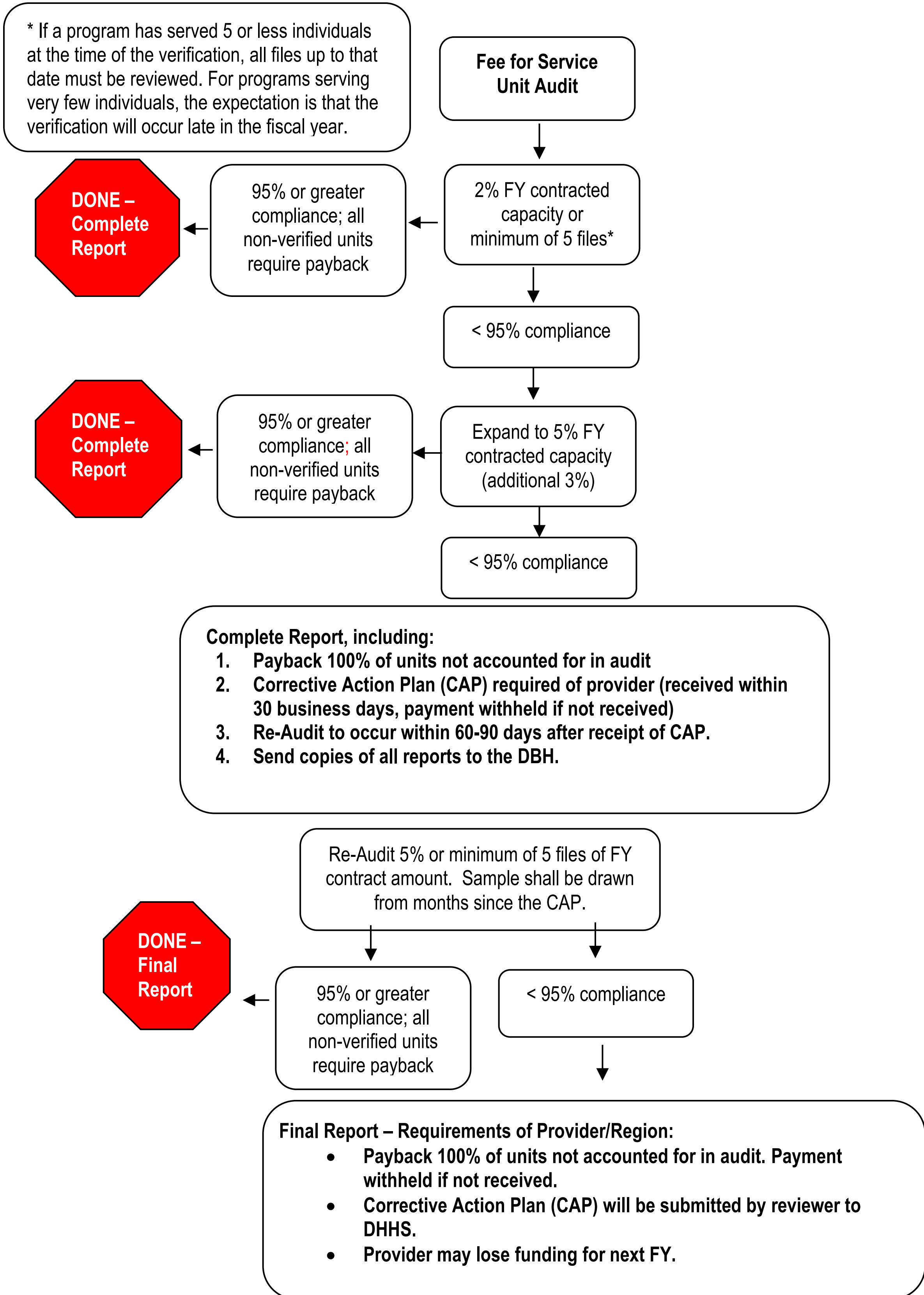
- Name of agency,
- Listing of documents that were reviewed,
- Listing of expenses and months that were reviewed,
- Narrative of findings,
- Corrective actions required,
- General comments and observations.

Reviewing CAPs that Cross Fiscal Years

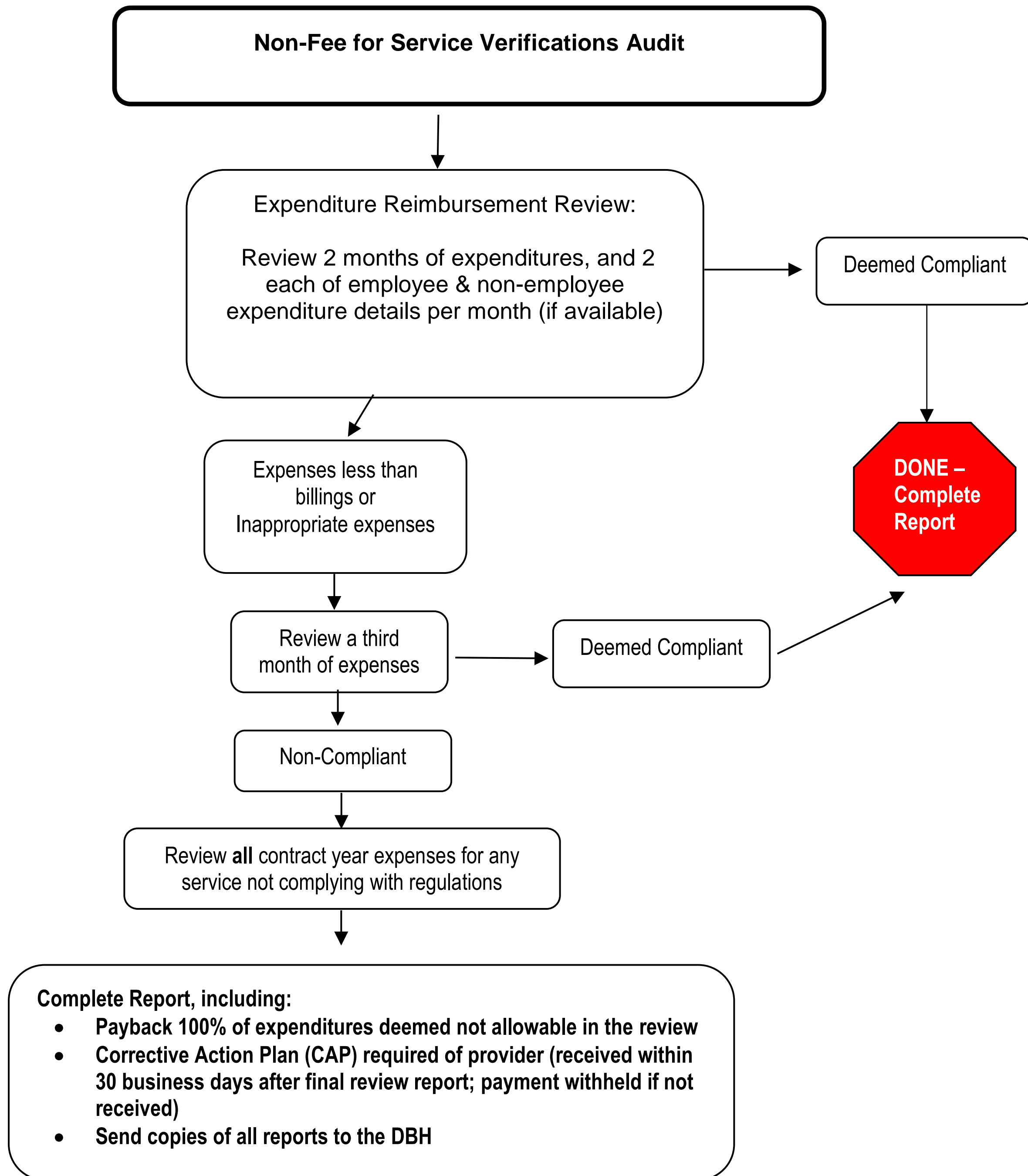
The re-review process for CAPs that cross fiscal years will be the same as a normal Services Purchased (unit/expense), and the re-audit may be incorporated within the normal state fiscal year audit. Re-audit shall consist of 5% or a minimum of 5 files for those services in which a CAP was in place. All other services will follow normal Services Purchased (unit/expense) 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 DBH.

Services Purchased Verification Decision Flowchart



Non-Fee for Services Verification Decision Flowchart



Complete Report, including:

- **Payback 100% of expenditures deemed not allowable in the review**
- **Corrective Action Plan (CAP) required of provider (received within 30 business days after final review report; payment withheld if not received)**
- **Send copies of all reports to the DBH**

PART VI:
Program Fidelity Reviews

Program Fidelity Review Process

Program Fidelity Reviews shall be conducted on each provider and service 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 and/or reviewer service definitions, and other mandatory guidelines for service provision.

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.

Pre-Visit:

Program Fidelity Reviews shall include of a minimum of three (3) files per service, per provider. The deadline for completion of Program Fidelity Reviews is October 31st following the fiscal year being reviewed in order to allow a more thorough review of June service units. Reviewers can choose from files being examined as part of the services purchased verification, or can use the TADs, or other DBH 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 material errors and recommendations needed
- Type of recommendations required
- Patterns or trends in files within the audited service or from multiple audited services provided by one service provider

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
- Program Review observations
- Suggestions / Recommendations
- Corrective actions required

The reviewer shall complete a report detailing the results of the review and distribute it to the provider within 45 business 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 will be submitted to reviewer within 30 business days of the notification that the provider did not meet compliance standards in the review.

Upon approval of the CAP, the reviewer 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 reviewer shall withhold payment from the provider for the identified service(s) until such required documentation is received by the reviewer. 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 DBH.

PART VII:
DBH Required Registration and Authorization

Turn-Around Document (TAD)

A TAD is available in the CDS at the end of a billable month. A provider accesses the DBH 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, RBHA Administration staff, and DBH 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.

Appendix A
Medical and Therapeutic Leave

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.

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 DBH will reimburse at the full program rate per day.

Appendix B
Mandatory Review Components 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.
- Documentation consumer meets financial eligibility criteria (family income, number of dependents) (P)
- Documentation of completed re-verification process every year to ensure continuing eligibility
- Documentation of completed verification process upon admission to ensure participant is indigent
- Signed copy of citizen attestation.
- Copy of completed consumer assessment, including the following:
  1. Assessment completed within timeframe per agency policy
  2. Assessment verifies participant meets eligibility requirements set by service definition
  3. Recommendations for services to include medical and/or psychological referral
  4. Licensed personnel signature, and, signature of fully licensed clinician approving this assessment
  5. Emphasis on strengths (P)
  6. Assessment of needs (P)
  7. Referral source (P), name and title of referral individual such as MD, psychologist, APRN, LIMHP
  8. Consumer name, 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:
  1. DSM diagnosis
  2. Primary/ideal level of care
  3. Available level of care/barriers to ideal level of care
  4. Documentation of consumer/family's response to recommendations
  5. 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):
  1. Signature of professional, participant, and/or parent/guardian signature, as applicable
  2. One (1) year scope
  3. Documentation which allows the DBH, its agent, and RBHA to receive confidential participant information
- Documentation that orientation was completed (P)
- Copy of completed Nebraska Voter Registration form as needed (P)
- 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):
  1. Current primary care physician (name and contact information)
  2. Date of last physical exam and the physician who performed exam
  3. 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;
  1. 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:
    1. Participant and/or parent/guardian signature, as applicable
    2. Licensed personnel's signature
    3. Documentation initial Tx plan completed within timeframe per agency policy (MH/SA) (30 days – OP/SA)
    4. Documentation Tx plan reviews completed within 90-day (OP/SA) timeframe per agency policy
    5. Measurable objectives (P)
    6. Start/stop times for outpatient group sessions, individual counseling, and Medication Management sessions
    7. Documentation Tx plan addresses needs identified in assessment (P)
    8. Frequency and duration of activities (P)
    9. Individualized goals (P)
    10. Description of therapeutic or support method (P)
    11. Documentation participant helped develop plan
    12. Indication why adjunctive services are an integral part of participant's care
    13. Documentation Tx plan addresses both SPMI and CD disorders (Dual only)
    14. Documentation 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)
    15. Prioritized measurable objectives that are time limited (P)
    16. Delineation of specific behavioral criteria for discharge/transition into a lower level of care).
- Documentation participant to therapist ratio is followed regarding group session: 12:1 (8:1 group 1:1 individual r1) (SA)
- Documentation agency has at least 50% of personnel that are LADAC's (SA)
- Includes documentation justifying length of service to a participant beyond one year and explaining why consumer's needs were not met in standard service time (exclude TC) (SA)
- Documentation requirements for day rehabilitation and for residential rehabilitation must:
    1. Provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided
    2. 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
    1. 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:
    1. Documentation complete & sufficient to determine content of session

2. Individual's participation & progress
3. Progress note(s) completed within timeframe per agency policy
4. 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 (SA)
  1. 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 (RBHA 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:
  1. Accessing and using medication;
  2. Accessing physical health care,
  3. Employment,
  4. Transportation,
  5. Social connectedness-formal and informal support systems, and
  6. 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)

Emergency Audit List

Client files must include the following:

A. Initial treatment information:

- Copy of completed admission form, which includes:
  1. Documentation the consumer and/or guardians, as appropriate, gave informed consent to treatment, rehabilitation and/or recovery services, medication usage and services to be provided.
  2. Documentation 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.
  3. Admission date in CDS agrees with date in participant file {excluding CRT}
- Signed copy of completed attestation form (Excluding EPC and CRT)
- Documentation consumer meets financial eligibility criteria (family income, number of dependents) (excluding CRT)
- Documentation of appropriate referral (Social Detox, CRT)
- Documentation program is available 24 hours per day, 7 days per week
- Copy of EPC certificate (EPC only)
- Copy of completed assessment, including:
  1. Assessment completed within timeframe per agency policy
  2. Assessment verifies participant meets eligibility requirements set by service definition (excluding CRT)
  3. Emphasis on strengths (within 72 hours for Social Detox) {excluding CRT} (P)
  4. Assessment of needs (within 72 hours for Social Detox) {excluding CRT} (P)
  5. Assessment includes a SA screening and/or psychometric tool (i.e.: SASSI) (EPC, Acute, Psych Respite)
  6. Referral source (P), name and title of referral individual such as MD, psychologist, APRN, LIMHP

7. Consumer name, 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:
  1. DSM diagnosis
  2. Primary/ideal level of care
  3. Available level of care/barriers to ideal level of care
  4. Documentation of consumer/family's response to recommendations
  5. 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 DBH, its agent, and RBHA to receive confidential participant information.
  1. Release of Information form includes one (1) year limit (excluding CRT)
- Documentation orientation was completed (excluding CRT) (P)
- Copy of completed Nebraska Voter Registration form as needed (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):
  1. Current primary care physician (name and contact information)
  2. Date of last physical exam and the physician who performed exam
  3. 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 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).
- Documentation psychological evaluation completed within 36 hours (EPC only)

F. Substance abuse information:
- Primary drug(s) of choice
    1. 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
- Documentation 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:
    1. Connection to alcohol/drug use
    2. Current legal charges/disposition of charges

H. Treatment Structure:
- Copy of completed treatment Tx plan, esp. information identified in assessment (excluding CRT):
    1. Psychiatric emergency, community living skills and ADLS, MM, MH services, physical health care, voc./educ., SA Tx
    2. Documentation of recovery services, including crisis/relapse plan
    3. Each entry must identify the date, location of service, first and last name, title of the staff person providing the service.
    4. Participant and/or parent/guardian signature, as applicable
    5. Start/stop times for outpatient group sessions, individual counseling, and Medication Management sessions
    6. Appropriate personnel's signature
    7. Documentation of Tx updates
    8. Tx plan reviews are completed within timeframe per agency policy (P)
    9. Measurable objectives (P)
    10. Documentation Tx plan addresses needs identified in assessment (P)
    11. Frequency and duration of activities (P)
    12. Individualized goals (P)
    13. Description of therapeutic or support method (P)

14. Documentation participant helped develop plan

- Documentation requirements for day rehabilitation and for residential rehabilitation must:
  1. Provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided
  2. Provide consumer's response to those interventions
  3. Show how significant consumer issues are shared between providers

I. Treatment record:

- Date of service indicated in participant file or emergency log
  1. Date of service in file agrees with date in CDS
- Length of service indicated in participant file
  1. Length of service in file agrees with timeframe in CDS
- Includes progress note(s) in participant record, showing:
  1. Documentation complete & sufficient to determine content of session,
  2. Individual's participation & progress
  3. Progress note(s) completed within timeframe per agency policy
  4. 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:
  1. Date and time of request, specific presenting problems, involvement of other parties, action taken, and disposition of episode (Social Detox, Psych Respite, and CRT)
- Recommendations for services to include referral for comprehensive SA assessment (MH) (P)
- Documentation of screening for referral to an inpatient psychiatric program (Social Detox and CRT)
- Documentation 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 Clinic/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:
  1. Accessing and using medication;
  2. Accessing physical health care,
  3. Employment,
  4. Transportation,
  5. Social connectedness-formal and informal support systems, and
  6. Financial resources

<u>Non-Residential</u>

<u>Client files must include the following</u>:

A. Initial treatment information:

- Copy of completed admission form in participant file
  1. 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
- Documentation consumer meets financial eligibility criteria (family income, number of dependents) (P)
    1. Documentation of completed re-verification process every year to ensure continuing eligibility
- Documentation of completed verification process upon admission to ensure participant is indigent
- Signed copy of citizen attestation
- Copy of completed consumer assessment, including the following
    1. Assessment completed within timeframe per agency policy
    2. Assessment verifies participant meets eligibility requirements set by service definition
    3. Recommendations for services to include medical and/or psychological referral
    4. Licensed personnel signature, and, signature of fully licensed clinician approving this assessment
    5. Emphasis on strengths (P)
    6. Assessment of needs (P)
    7. Referral source (P), name and title of referral individual such as MD, psychologist, APRN, LIMHP
    8. Consumer name, emergency contact (name, relationship, and contact information), and any other relevant consumer information
- Prior treatment plan(s), as appropriate
- Provider demographics including:
    1. 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:
    1. DSM diagnosis
    2. Primary/ideal level of care
    3. Available level of care/barriers to ideal level of care
    4. Documentation of consumer/family's response to recommendations
    5. 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):
    1. Signature of professional, participant, and/or parent/guardian signature, as applicable
    2. One (1) year scope
    3. Documentation which allows the DBH, its agent, and RBHA to receive confidential participant information
- Documentation that orientation was completed (P)

- Copy of completed Nebraska Voter Registration form as needed (P)
- 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):
  1. Current primary care physician (name and contact information)
  2. Date of last physical exam and the physician who performed exam
  3. 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;
  1. 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:
  1. Connection to alcohol/drug use
  2. Current legal charges/disposition of charges

H. Treatment structure:

- Copy of completed treatment Tx plan, including:

1. Participant and/or parent/guardian signature, as applicable
2. Appropriate and/or licensed personnel's signature, as needed
3. Documentation initial Tx plan completed within timeframe per agency policy (MH/SA) (30 days - OP/SA)
4. Documentation Tx plan reviews completed within 90-day (OP/SA) timeframe per agency policy
5. Measurable objectives (P)
6. Documentation Tx plan addresses needs identified in assessment (P)
7. Frequency and duration of activities (P)
8. Individualized goals (P)
9. Start/stop times for outpatient group sessions, individual counseling, and Medication Management sessions
10. Description of therapeutic or support method (P)
11. Documentation participant helped develop plan
12. Indication why adjunctive services are an integral part of participant's care
13. Documentation Tx plan addresses both SPMI and CD disorders (Dual only)
14. Crisis/Relapse Prevention, (SPMI & CD/SA)
15. Documentation 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)
16. Prioritized measurable objectives that are time limited (P)
17. Delineation of specific behavioral criteria for discharge/transition into a lower level of care
18. Recommendations for referral to other services, as appropriate (P)

- Documentation participant to therapist ratio is followed regarding group session: 12:1 (SA)
- Documentation agency has at least 50% of personnel that are LDAC's/PLDAC'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 and explaining why consumer's needs were not met in standard service time (SA)
- Documentation requirements for day rehabilitation and for residential rehabilitation must:
  1. Provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided
  2. 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
  1. Date of service in file agrees with date in CDS
- Length of service indicated in participant file
  1. 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:
  1. Documentation complete & sufficient to determine content of session,
  2. Individual's participation & progress
  3. Progress note(s) completed within timeframe per agency policy
  4. Frequency of progress notes sufficient with respect to intensity of treatment or programs/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)

- Documentation telephone contact was documented as therapeutic, billed and/or billing state available (Dual only)
- Documentation Service activity described fits within the service definition
- Documentation of recovery services
  1. 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
- Documentation 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:
  1. Accessing and using medication;
  2. Accessing physical health care,
  3. Employment,
  4. Transportation,
  5. Social connectedness-formal and informal support systems, and
  6. 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)

Psychosocial Audit List

Client files must include the following:

A. Initial treatment information:

- Copy of completed admission form in participant file
  1. 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.
- Documentation consumer meets financial eligibility criteria (family income, number of dependents) (P)
  1. Documentation of completed re-verification process every year to ensure continuing eligibility
- Documentation 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
  1. Assessment completed within timeframe per agency policy
  2. Assessment verifies participant meets eligibility requirements set by service definition
  3. Recommendations for services to include medical and/or psychological referral
  4. Mechanism to refer consumers for comprehensive SA assessment (MH)
  5. SA screening and/or psychometric tool (i.e. SASSI) (MH)
  6. Appropriate personnel signature, and signature of fully licensed clinician approving this assessment
  7. Assessment of strengths and needs (P)
  8. Referral source (P), name and title of referral individual such as MD, psychologist, APRN, LIMHP
  9. Consumer name, emergency contact (name, relationship, and contact information), and any other relevant consumer information
- Provider demographics including:
  1. 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:
  1. DSM diagnosis
  2. Primary/ideal level of care
  3. Available level of care/barriers to ideal level of care
  4. Documentation of consumer/family's response to recommendations
  5. 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):
  1. Signature of professional, participant, and/or parent/guardian signature, as applicable
  2. One (1) year scope
  3. Documentation which allows the DBH, its agent, and RBHA to receive confidential participant information
- Documentation that orientation was completed (P)
- Copy of completed Nebraska Voter Registration form as needed (P)
- 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):
  1. Current primary care physician (name and contact information)
  2. Date of last physical exam and the physician who performed exam
  3. 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;
  1. 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:
  1. Connection to alcohol/drug use
  2. Current legal charges/disposition of charges

H. Treatment structure:
- Copy of completed treatment Tx plan, including:
  1. Participant and/or parent/guardian signature, as applicable (MH)
  2. Appropriate and/or licensed personnel's signature, as needed
  3. Documentation initial Tx plan completed within timeframe per agency policy (MH/SA) (30 days - OP/SA)
  4. Documentation Tx plan reviews completed within 90-day (OP/SA) timeframe per agency policy
  5. Measurable objectives (P)
  6. Documentation Tx plan matches assessment (P)
  7. Frequency and duration of activities (P)
  8. Start/stop times for outpatient group sessions, individual counseling, and Medication Management sessions
  9. Individualized goals (P)
  10. Description of therapeutic or support method (P)
  11. Documentation participant helped develop plan
  12. Indication why adjunctive services are an integral part of participant's care
  13. Documentation Tx plan addresses both SPMI and CD disorders (Dual only)
  14. Crisis/Relapse Prevention, (SPMI & CD/SA)
  15. Documentation 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)
  16. Prioritized measurable objectives that are time limited (P)
  17. Delineation of specific behavioral criteria for discharge/transition into a lower level of care
  18. Recommendations for referral to other services, as appropriate (P)

- Copy of completed integrated Tx that addresses one or more of the following, as applicable:
  1. Community living skills
  2. ADLS
  3. Interpersonal skills
  4. Psychiatric emergency/relapse
  5. MM
  6. Mental health services
  7. Physical healthcare
  8. Vocational/educational services
  9. Substance abuse services
  10. Resource acquisition
- Documentation proper participant to therapist ratio is followed regarding group session: 12:1 (SA)
- Documentation 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:
  1. Provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided
  2. 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
  1. Date of service in file agrees with date in CDS
- Length of service indicated in participant file
  1. 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:
  1. Documentation complete & sufficient to determine nature/content of services,
  2. Individual's participation & progress
  3. Progress note(s) completed within timeframe per agency policy
  4. 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
- Documentation service activity described fits within the service definition
- Documentation of recovery services
  1. 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
- Documentation 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:
  1. Accessing and using medication;
  2. Accessing physical health care,
  3. Employment,

4. Transportation,
5. Social connectedness-formal and informal support systems, and
6. 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)

Appendix C
Supported Employment Reviews

Review Process

Supported Employment as a service has a unique status in the behavioral health system, due to its hybrid billing nature and braided-funding status. As such, it should be reviewed in a manner specific to the unique aspects of the service itself. Supported Employment's unique billing requirements and service delivery expectations dictate an in-depth review of the data entered for each encounter, as well as the timelines that accompany them. The process and standards described herein are requirements **in addition to** those described above. Please reference the Supported Employment Manual for more guidance and for the Supported Employment Audit Tool.