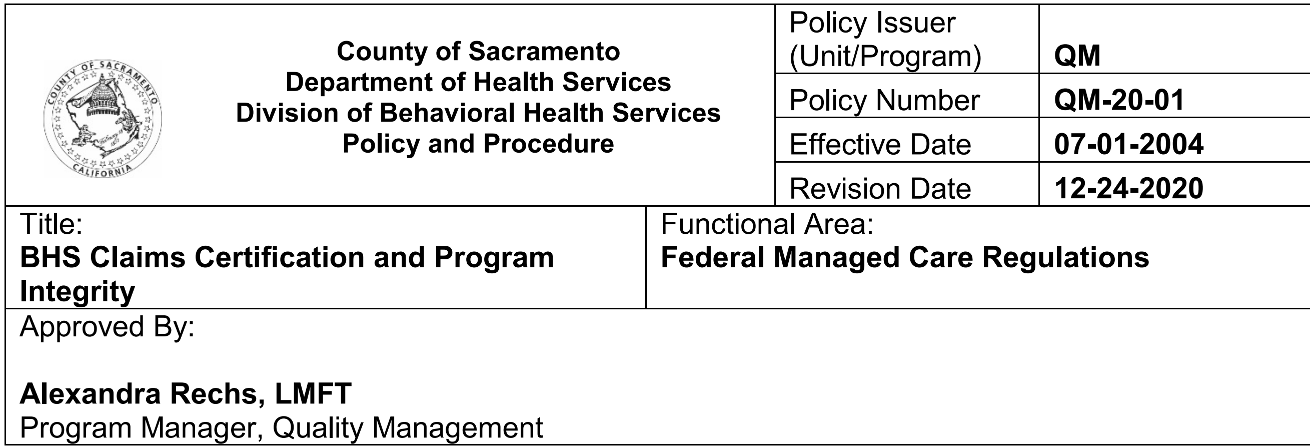

County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure		Policy Issuer (Unit/Program)	**QM**
		Policy Number	**QM-20-01**
		Effective Date	**07-01-2004**
		Revision Date	**12-24-2020**
Title: **BHS Claims Certification and Program Integrity**	Functional Area: **Federal Managed Care Regulations**		
Approved By: **Alexandra Rechs, LMFT** Program Manager, Quality Management			

BACKGROUND/CONTEXT:

It is the policy of the Sacramento County Division of Behavioral Health Services (BHS) and the Mental Health Plan (MHP) to submit claims to the State of California for Medi-Cal reimbursement in compliance with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, §§ 438.604, 438.606, and, as effective August 13, 2003, § 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), and Title 9, California Code of Regulations, Division 1, Chapter 11, Subchapter 4, Article 1, § 1840.112.

PURPOSE:

To purpose of this policy is provide a process to ensure compliance with Federal regulations as referenced above regarding the provision and verification of Medi-Cal services authorized and provided through BHS and it's contracted providers.

DETAILS:

Documentation Requirements:

All Medi-Cal services claimed shall be supported by the following procedures and documentation: Core Assessments and Client Plans will be completed and maintained in the client electronic health record (EHR), in compliance with all BHS Policies and Procedures.

All requests for mental health services are received by the centralized Adult and Children's Access Teams on behalf of the MHP. Initial eligibility for services is established by the Access Teams and subsequent verification is conducted by the assigned service provider. Medi-Cal eligibility shall be verified and documented prior to the authorization of any behavioral health service on a monthly basis, by all behavioral health providers, as per agreed upon contract and in compliance with all BHS Policies and Procedures. Subsequent verification is conducted by assigned service provider.

All Medi-Cal services claimed shall be provided in accordance with all BHS Policies and Procedures and shall be supported by a completed Progress Note retained in the client EHR. All progress notes will be electronically signed by the author, as an attestation, that the services were delivered in accordance with Title 42, Code of Federal Regulations.

Medical necessity shall be established for each beneficiary, as defined in Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided, and in accordance with all BHS Policies and Procedures. The establishment of medical necessity shall be documented with a completed Core Assessment, Client Plan, and a Progress Note. All documentation is to be retained in the EHR, including appropriate authorization forms from the ACCESS team.

A Client Plan shall be developed and maintained on an annual basis for each beneficiary in accordance with all BHS Policies and Procedures. Designated programs or services abide by Access Team Policies for more frequent reassessments required for continued authorization.

All day rehabilitation, day treatment intensive, or EPSDT supplemental specialty mental health services shall be pre-authorized and shall meet all regulatory requirements in accordance with all BHS Policies and Procedures, prior to any claim for such services provided.

Service Verification:

All BHS Contracted and County Operated Service providers will implement a service verification survey to verify that a service claimed was provided to the beneficiary. It is the intent of the MHP to verify at least 5% of client visits per month.

Upon completion of a face to face service, providers will offer clients a short survey that verifies receipt of mental health services on that visit. The survey will ask which provider(s) were met with and the approximate length of their appointment (see Attachment "A- Services Verification Card (English)". Surveys are translated into all of the BHS threshold languages (See Attachments B-H).

A provider staff member other than the staff that provided the service shall be responsible for verifying services. Services will be verified by matching a random sample of the Survey responses received each month (random sample must be equal to at least 5% of the client visits in the month) with the corresponding billed claims documented in the electronic health record. Providers are responsible for ensuring that the Surveys used to verify services are chosen using a randomized selection method.

Any inconsistencies in billing, claiming, and documentation will be investigated by the Clinical Director to determine if the claim was an innocent error or a fraudulent act. If a fraudulent act is suspected, the Clinical Director will contact the DBHS Compliance Officer for further investigation and reporting in accordance with the BHS Compliance Program and BHS Issue Reporting Policies.

Inconsistencies determined to be an innocent error will be processed in accordance with the Deletion of Open Charges and Claims Policy.

If the provider is not using the BHS Compliance Program policies, the agency must update their Compliance Program policies to include the Service Verification Process described in this document. Providers will send a copy of the updated policies to the BHS Compliance Officer.

Surveys will be provided to providers in all MHP Threshold Languages.

Providers must report the monthly survey results in the QM section of the Quarterly Report submitted to the Program Contract Monitor for QM review by the 10th of the subsequent month.

Providers must save all surveys (even though only 5% are verified) and a copy of the Quarterly Report for at least three years. Surveys used in the verification of services should be easily identifiable and all surveys must be readily accessible upon request of a County representative for monitoring and auditing purposes.

REFERENCES:

- Title 42, Code of Federal Regulations, §438.608
- Title 42, Code of Federal Regulations, §455.1(a)(2) and §455.20(a)
- Title 9, California Code of Regulations, §1840.112
- Social Security Act, Subpart A §1902(a)(4) and §1909
- MHP Contract, Exhibit A, Attachment I

ATTACHMENTS:

- A-Service Verification Card (English)
- B-Service Verification Card (Russian)
- C-Service Verification Card (Spanish)
- D-Service Verification Card (Vietnamese)
- E-Service Verification Card (Cantonese)
- F-Service Verification Card (Hmong)
- G-Service Verification Card (Arabic)
- H-Service Verification Card (Farsi)

RELATED POLICIES:

- No. 10-25 Client Plan
- No. 10-03 Progress Notes
- No. 10-26 Core Assessment
- No. 00-08 Deletion of Open Charges and Claims
- No. 44-01 DBHS Issue Reporting
- No. 41-01 DBHS Compliance Program
- No. 41-03 DBHS Code of Conduct

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Behavioral Health Staff		
	Mental Health Treatment Center		
X	Adult Contract Providers		
X	Children's Contract Providers		
	Substance Use and Prevention Treatment		

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