Outpatient Behavioral Health Services Audit Tool

Effective 7/1/2024

Audits are intended to inform, promote, and evaluate a provider's adherence to documentation standards, support the provision of services that enrich the quality of member care, as well as continually improve the lives of Members. Audits provide oversight of network providers and ensure adherence to provider contracts. It is encouraged that providers develop their own internal audit system. This audit tool is a resource and is not intended to replace or supersede coding-specific guidance in the SBHS Billing Manual, CPT coding guidelines, or any state and federal regulations, including CMS requirements. This tool supports documentation requirements for Outpatient Behavioral Health Services provided to Health First Colorado Members. It is not comprehensive of regulatory expectations for documentation of services for providers holding specific licenses under the Behavioral Health Administration or expectations for other specific professional licensures or regulatory agencies. General Documentation items will be reviewed from a compliance perspective and would be subject to provider coaching and/or recoupment based on the significance of any infraction. The Assessment and Treatment Plan items are reviewed from a quality perspective that supports medical necessity standards. All Colorado RAEs are in agreement with the standards herein. RAEs reserve the right to place providers on monitoring status and conduct future audits to ensure compliance with the terms of the provider contract, as well as billing, coding, and documentation requirements.

Section A: General Documentation

Information that must be documented for all clinical encounters submitted for reimbursement

Item	Requirement/Standard Description	Regulation/Citation/ Basis for Standard
D1	Member's name or Medicaid ID is listed on each document within the record	Annual RAE BH Encounter Data Quality Review Guidelines
D2	Member or Guardian constent to participate in services is present	SBHS Section VIII (House Bill 19-1120 permits situations for age 12 and above consent to treatment as clinically indicated)
D3	Member or Guardian's verbal or written consent to participate in Telehealth services is present (as appropriate)	SBHS Section VII
D4	Date of service is domumented	SBHS Section VIII
D5	Start and end time of service or service duration is documented	SBHS Section VIII

D6	Place of service is documented	SBHS Section VIII
D7	Reason for the encounter is doumented	SBHS Section VIII
D8	Description of service provided and/or interventions utilized is documented	SBHS Section VIII
D9	Member's response to the service and/or progress towards treatment goals from the service provided (as appropriate) is documented	SBHS Section VIII
D10	Notes address suicide risk as needed until risk is resolved (as appropriate) is documented	Practice Guideline for Assessment and Treatment of Patients with Suicidal Behaviors; https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf
D11	Plan for next contact/Care coordination and/or Referrals (as appropriate) is documented	SBHS Section VIII
D12	Care Coordination and referral outcomes are documented (as appropriate) is documented	SBHS Section VIII
D13	Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held.	SBHS Section VIII
D14	Interpretation/translation services are documented (as appropriate)	All RAEs in agreement with this standard, referenced in RAE specific provider manuals
D15	Documentation is legible	CMS Evaluation and Management Services Guide https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf; CMS §482.24(c)(1)
D16	Documentation supports use of CPT/HCPCS code billed for service	SBHS Section VIII
D17	Evidence of documentation for no show appointments or drop out of services is present (as appropriate)	SBHS Section VI. D
D18	Clinical rationale and medical necessity for the service is documented	SBHS Section VI. A ; SBHS Section VIII

Medical Necessity Documentation Demonstrating medical necessity for assessment and treatment planning services includes generating an assessment and treatment plan in addition to documentation of the assessment or treatment planning service provided. These clinical documents include the following information.			
Section B: Assessment			
Item	**Requirement/Standard Description**		**Regulation/Citation/ Basis for Standard**
A1	Assessment	Formal Risk Assessment/screen present, including Suicide question and Homicide quesiton, inlcuding Safety plan/crisis plan is present (if applicable)	CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf
A2	Assessment	Chief Complaint/Problem Statement is present	SBHS Section VIII; SBHS Assessment and Treatment Code Pages; CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf
A3	Assessment	Psychiatric/Mental Health History is documented	SBHS Section VIII; SBHS Assessment and Treatment Code Pages; CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf
A4	Assessment	Complete Mental Status Evaluation is documented	SBHS Section VIII; SBHS Assessment and Treatment Code Pages
A5	Assessment	Client Strengths, skills, abilities, interests are documented	CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf
A6	Assessment	Complete psychosocial history is documented including family, social history and cultural issues	SBHS Assessment Code Pages

<table>
<tr><td>A7</td><td>Assessment</td><td>History including pre/perinatal events, physical/emotional/social/ intellectual growth & development, school adjustment & performance, typical activities & interests, behavior mgmt skills, social skills issues. Assessment includes review of developmental history, delays or disabilities, functional difficulties related to aging, etc.</td><td>SBHS Assessment Code Pages</td></tr>
<tr><td>A8</td><td>Assessment</td><td>Medical/ dental history, symptoms, severity and necessity is documented.</td><td>CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf</td></tr>
<tr><td>A9</td><td>Assessment</td><td>Substance Use/Abuse History is documented</td><td>SBHS Assessment Code Pages</td></tr>
<tr><td>A10</td><td>Assessment</td><td>Prescribed medication(s) is documented</td><td>CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf</td></tr>
<tr><td>A11</td><td>Assessment</td><td>Behavioral Health Diagnoses with supporting evidence is documented</td><td>SBHS Assessment Code Pages , SBHS Section VIII</td></tr>
<tr><td colspan="4">Section C: Treatment Plan</td></tr>
<tr><th>Item</th><th colspan="2">Requirement/Standard Description</th><th>Regulation/Citation/ Basis for Standard</th></tr>
<tr><td>T1</td><td>Treatment Plan</td><td>Treatment plan is individualized, stengths-based and culturally sensitive</td><td>CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf</td></tr>
<tr><td>T2</td><td>Treatment Plan</td><td>Treatment plan includes short and long terrm goals in a manner understandable to the individual.</td><td>CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf</td></tr>
<tr><td>T3</td><td>Treatment Plan</td><td>Treatment interventions include specific types and frequency of services</td><td>CMS Mental Health Coverage https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf</td></tr>
<tr><td>T4</td><td>Treatment Plan</td><td>Risk/harm/SI concerns are addressed in plan</td><td>Practice Guideline for Assessment and Treatment of Patients with Suicidal Behaviors; https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf</td></tr>
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