

**BEHAVIORAL HEALTH EVALUATION TOOL**  
**HCCA 2008 Compliance Institute - April 14<sup>th</sup> Breakout Session:**  
*Behavioral Health: Managing the Increased Scrutiny of Medicaid Fraud, Abuse and Waste*  
*Speakers: Terry Haru, Ph.D. • Dean True, RN, CHC*

FISCAL AND CLINICAL AREAS OF RISK	YES	NO	COMMENTS
<b>FISCAL Practices</b>			
<b>Billing Practices</b>			
Are there written Policies / Procedures / Protocols in place that address the issue of billing practices, denied claims, etc.? If so, have they been 'screened' for compliance with State Medicaid regulations, and has fiscal staff been adequately trained in them?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the billing system have 'safeguards' in place that catch / prevent mistakes <i>before</i> claims are submitted? (Examples: if there is a maximum billable time/amount for a service, is the system set to accept only the 'max', can only qualified staff bill/claim for specific services, and will the system automatically 'screen out / not accept' mistakes, etc. If not, consider/explore implementing such a system)	<input type="checkbox"/>	<input type="checkbox"/>	
Are regularly scheduled audits being conducted, and do they include a review of comparing billings submitted with clinical documentation?	<input type="checkbox"/>	<input type="checkbox"/>	
Do audits focus on assessment of billing systems, accuracy of claims, and identify the root cause of billing errors?	<input type="checkbox"/>	<input type="checkbox"/>	
Has a review of billing 'patterns' been conducted, and if available, are they in step with providers of similar size delivering similar services?	<input type="checkbox"/>	<input type="checkbox"/>	
Has a review of general systems been conducted that checks accuracy and compliance with basic State Medicaid Regulations - including reviews of 'cost reporting' procedures/practices?	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>FISCAL AND CLINICAL AREAS OF RISK</b>	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
<b>FISCAL Practices</b>			
<b>Denied Claims</b>			
Does the organization routinely monitor receipts of denied claims?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the organization have a 'denied claims' rate, and is there a written corrective action plan that identifies a specific reduction target with appropriate interventions to correct identified problems?	<input type="checkbox"/>	<input type="checkbox"/>	
If an internal plan of correction to reduce denied claims has been written, has it been implemented, and is it being monitored for effectiveness / follow through?	<input type="checkbox"/>	<input type="checkbox"/>	
Are overpayments promptly refunded?	<input type="checkbox"/>	<input type="checkbox"/>	
Are findings, status, and outcomes of 'denied claim' reports routinely provided to appropriate oversight committees, including senior management?	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>CLINICAL Practices</b>			
<b>Qualifications of Staff</b>			
Are job descriptions/specifications for education and experience in accordance with State Medicaid regulations?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there written Policies / Procedures / Protocols in place that outline staff qualifications and what services they may bill, and have audits been conducted to monitor compliance in this area?	<input type="checkbox"/>	<input type="checkbox"/>	
If indicated - is there a general 'Scope of Practice' grid that indicates who in the organization may conduct / claim for various qualified Medicaid reimbursement? Has staff been adequately trained to it?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the clinical staff delivering Medicaid reimbursable services been trained to general requirements / regulations?	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>CLINICAL Practices</b>			
<b>Assessment and establishment of medical necessity</b>			
Are there written Policies / Procedures / Protocols in place that address the issue of assessment and medical necessity including timeframes for completion of necessary documentation, identify staff responsible? If so, have they been 'screened' for compliance with State Medicaid regulations, and has staff been adequately trained in them?	<input type="checkbox"/>	<input type="checkbox"/>	
Do current clinical assessment forms contain all necessary elements outlined in State Medicaid regulations?	<input type="checkbox"/>	<input type="checkbox"/>	
Are routine audits screening for documentation of diagnostic criteria outlined in the Diagnostic & Statistical Manual (DSM) IV TR in individual client records?	<input type="checkbox"/>	<input type="checkbox"/>	
Are 'functional impairments' (impairment in an important area of life functioning) appropriately identified and documented in individual client records, and are these related/tied to DSM IV TR diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	
When auditing individual records, is there consideration/screening (given documented diagnosis and level of impairment) that expected services will alleviate, prevent the worsening of, improve, correct, or cure?	<input type="checkbox"/>	<input type="checkbox"/>	
Are services being provided in the least restrictive, most cost-effective manner?	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>CLINICAL Practices</b>			
<b>Individualized Treatment Plans</b>			
Are there written Policies / Procedures / Protocols in place that address the issue of the client treatment plan, timeframes, and identifies staff that are to complete them? If so, have they been 'screened' for compliance with State Medicaid regulations, and has staff been adequately trained in them?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there written plans present in all client records, and do they establish observable/measurable goals related to documented diagnosis and impairments?	<input type="checkbox"/>	<input type="checkbox"/>	
Does each written plan contain industry recognized interventions, and identify who will provide these interventions/services?	<input type="checkbox"/>	<input type="checkbox"/>	
Does each written plan contain timeframes for evaluating / reaching goals?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a process in place, and is there evidence that, written plans are reviewed periodically for effectiveness and/or a need for revision?	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>CLINICAL Practices</b>			
<b>Progress Notes</b>			
Are there written Policies / Procedures / Protocols in place that address the issue of individual progress notes, timeframes for completion, identifies staff that are to complete them and/or the need for co-signatures? If so, have they been 'screened' for compliance with State Medicaid regulations, and has staff been adequately trained in them?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there progress notes in place for each claim, do the contents meet general State Medicaid expectations/guidelines (if any), and are there routine audits in place? (Available Medicaid audit results from CMS/OIG on community mental health services indicate that 'missing' documentation (no note) continues to be a significant reason for disallowances and extrapolated \$\$ penalties)	<input type="checkbox"/>	<input type="checkbox"/>	
Do progress notes consistently describe services/ interventions that are consistent with written client plan? Are there routine audits looking for these issues, and what have been their findings?	<input type="checkbox"/>	<input type="checkbox"/>	
Do progress notes consistently describe the client's present condition, and response to, each service contact?	<input type="checkbox"/>	<input type="checkbox"/>	
Do progress notes consistently describe activities/ actions/ homework the client should be engaging in until next scheduled service contact?	<input type="checkbox"/>	<input type="checkbox"/>	