

## Handout # 1

Division of Prevention and Behavioral Health Services  
1825 Faulkland Road  
Wilmington, DE 19805



Hello,

The Division of Prevention and Behavioral Health Services (DBPHS) requires that all contracted providers be monitored to assure that quality services who are being provided to all children and families receiving direct services for mental health and substance abuse.

Therefore, DPBHS' Monitoring Team will be visiting your facility on days and month. We will be reviewing information in six primary areas. Below you will find the areas and what we are looking for specifically in those areas. We request that you have the following items available for us when we are on-site:

- A. Clinical Chart Reviews- In this section we are reviewing your charts for compliance with standards established in your contract. This may include, but is not limited to:
1. Certificate for Medical Necessity (when applicable)
  2. Service Admission Form (SAF)
  3. Admission Face Sheet
  4. Signed Physician's Orders (when applicable)
  5. Psychiatric Evaluation (when applicable)
  6. Medication Administration Record (MAR) (when applicable)
  7. 24-hour Patient Care/Monitoring (when applicable)
  8. Laboratory and Diagnostic tests/reports (when applicable)
  9. Assessment, Safety plan(s) (when applicable)
  10. Admission Summary
  11. Treatment plan which includes goals consistent with the SAF, goals in consumer language, risks being addressed, signatures of consumer, guardian, clinician, psychiatrist (if plan includes medication), and supervisor
  12. Progress notes that show collaboration with involved parties, notes are dated, specify length and type of session, list participants, and are signed by a supervisor when the clinician is not licensed, notes are linked to

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treatment goals, and risks are addressed

### 13. Discharge Summary

Please provide all client charts for the timeframe above

- B. Supervision- In this section we are verifying that you have documentation to support the requirement that staff providing direct clinical services are receiving the required amount of supervision.

Please provide:

1. Supervision notes on clinical staff and supervisors
2. Complete list of clinical staff including degree, title, and name of supervisor

- C. Incident/Safety Reports- In this section we review the timeliness of your incident reporting submission, and the quality and accuracy of the information submitted in the incident reports submitted.

- D. Clinical Deliverables – In this section we review applicable deliverables and if they were received in the appropriate timeframe to determine an overall compliance rating.

- E. Environment of Care-In this section we review, when applicable, your most recent accreditation, licensing and, any other applicable reports. We ask that you have available:

1. A copy of your most recent accreditation report and your response to any recommendations.
2. A copy of your most recent licensing report and your response to any recommendations

- F. Billing Audits- In this section we review what you have submitted for payment against the written documentation in the client charts.

1. Please provide all client charts for the timeframe above

**Attached to this email, please find and complete the clinical staff overview form and return it to me by within 5 days.**

Additionally, we will need a small meeting room which can hold 4-5 people.

Please let us know if you will serve as the liaison for our visit or whom we should be in contact with.

We look forward to having this opportunity to review your hard work and efforts. Following our review, we will provide you with a summary of what we identified to be your strengths and/or areas where improvement would be beneficial.

Please contact me with any questions or concerns.





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1825 Faulkland Road  
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## **PROGRAM MONITORING REPORT**

**Provider:**

**Service Type:**

**DATE OF MONITORING VISIT:**  
**DATE OF REPORT:**

**DPBHS Monitoring Team Members:**

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### SURVEY FINDINGS AND RECOMMENDATIONS

The monitoring survey is designed to assess the service provider's performance, to offer consultation to improve performance of network providers, and to facilitate coordination of DPBHS and network provider performance improvement initiatives.

A general overview of survey results are communicated to the network provider during an Exit Interview. A comprehensive written monitoring report is then prepared and mailed to the provider. The monitoring report identifies program strengths as well as recommendations for improvement. Please see the end of this report for more information regarding expectations around provider response to this report.

The following rating scale is applied in our monitoring:

Performance Rating	Action Requirements
90% -100% - Compliant	None
75% - 89% - Substantial Compliance	Performance Improvement Plan Required
50% - 74% - Average Compliance	Corrective Action Required
1% -49% - Low Compliance	Corrective Action Required
0% - No Compliance	Corrective Action Required

Survey results are reported to the DPBHS Quality Management Committee.

#### Entrance Interview:

A representative from DPBHS met with

In general, how is your agency doing?

What treatment models are used in your program?

What youth are you most successful with?

Which clients are the hardest for you to serve?

Who are the clients with the longest length of stay and why do you think they remain in treatment?

What is the most significant quality improvement /PIP that you are working on internally?

What outcome measures are you using and what are you finding?

#### 1. Clinical Chart Reviews:

##### Compliance Rating:

During the FY 2012 year, ?? clients were served. ?? client charts were reviewed for content; thus, ??% of client charts were reviewed. Several clients had multiple treatment episodes at \_\_\_\_ resulting in review of ?? treatment episodes. ?? treatment episodes were \_\_\_\_\_ care while ?? were \_\_\_\_\_ service episodes.

Item	# Present	# Due	% Compliance	NA
Certificate for Medical Necessity (FACTS)				
SAF				
Admission Face Sheet				
Standardized Assessment				
Safety Plan, if applicable				
Standardized Admission Summary				

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GAIN Short Screener (non SA programs, age 12+)				
Assisted in application for insurance, if appropriate				
Physician Orders (signed)				
Psychiatric Evaluation (if applicable)				
Medication Administration Record (MAR)				
24-hour Patient Care/Monitoring (as appropriate)				
Laboratory and Diagnostic test/reports where appropriate				
Standardized Treatment Plan				
If LOC change, a revised treatment plan, within timeframe				
Treatment Plan and Goals (assess->tx plan->notes->maintain justification)				
TX goals consistent with SAF				
Goals in client language				
Plan address identified risk				
Signed by clinician Client (14+) Custodian Psychiatrist Supervisor (if approp)				
Progress Notes show collaboration with: CSM School DFS YRS Informal supports Step down provider Other				
Progress notes are Dated Specify length Specify type of session List participants				
Progress Notes link to treatment goal(s)				
Used as indicated: GAIN (all SA) UCLA PCIT				
Notes co-signed				
Transfer Instruction Sheet				
Standardized Discharge Summary				

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Total Compliance Rating					
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Strengths:

Recommendations:

## 2. Supervision Compliance Rating:

Staff Name	Position	Credentials	Supervision (frequency, by whom)

Standard	# Present	# Due	NA	Compliance
Records of supervision				
<b>Total Compliance Rating</b>				

Strengths:

Recommendations:

## 3. Incident/Safety Reports Compliance Rating:

Incident reporting standards are specified in the DPBHS Provider Manual and the DSCYF Operating Guidelines. Initial report of an incident is to occur by verbal notification within the prescribed timelines followed by a detailed written incident report to be sent to the DPBHS Quality Improvement Unit within 72 hours of the event.

FY 2012			
Provider	Number Received	Number Received within 72 hours	Timeliness

Incident Type	Number Received	Number Received within 72 hours
<b>Total</b>		

Strengths:

Recommendations:

## 4. Clinical Deliverables Compliance Rating—Unable to Assess

Deliverable reporting standards are specified in the DPBHS Provider Manual and the DSCYF Operating Guidelines.

FY 2012 (July 1, 2011–June 30, 2012)							
	Certificate of Need (if applicable)	Safety Plan (if applicable)	Admission Summaries	Comprehensive Treatment Plans	Revised Treatment Plan (if	Transfer Instruction Sheet	Discharge Summaries

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					applicable)		
# Due							
# Rec'd							
# Rec'd on Time							
Compliance Rate (Based on #due and # rec'd on time)							

## 5. Environment of Care

Has maintained accreditation status:  Yes  No  N/A

Has maintained licensure status:  Yes  No  N/A

Has maintained any other regulatory body? status:  Yes  No  N/A

### Licensure:

Provider is licensed by \_\_\_\_\_.

Date of most recent visit:

Licensure Status:

Length of Licensure:

Recommendations addressed in plan by provider:

Expectations:

- 1) Comply with all accreditation standards and requests.
- 2) Advise PBHS immediately of any changes in licensure status.

### Accreditation

Provider is accredited by \_\_\_\_\_.

Date of most recent survey:

Accreditation Status:

Length of Accreditation:

Recommendations addressed in plan by provider:

Expectations:

- 1) Comply with all accreditation standards and requests.
- 2) Advise PBHS immediately of any changes in accreditation status.

## 6. Billing audits

*Compliance Rating:*

*\*failure to have 100% compliance in this area requires corrective action.*

Error Type	Number of claims
<b><u>Non-Compliant Claims</u></b>	
No documentation	
Insufficient documentation	
Medically unnecessary services	
Incorrect coding	
other	
<b>Total Claim Errors</b>	
<b>Total Claims reviewed</b>	

Strengths:

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Recommendations:

### **Conclusion**

This report describes general trends in performance and provides detailed information regarding areas that need improvement in order to meet DPBHS requirements. It is expected that the agency will incorporate all “Recommendations” into their practice and will inform DBPHS of how they will do so. Please format your response in such a manner as to list the section of the report, followed by the recommendation, followed by your response; please follow the same order as this report.

For example:

Section:	Rating:	DPBHS Recommendation #:	Provider Response:
Clinical Chart Review	81%	1: Treatment plan goals should be written in client language	Staff will be trained on the expectation and how to incorporate client/family language into treatment goals. Training will be provided on 1/1/12. Supervisors will be responsible to ensure this has occurred prior to signing off on a treatment plan.

Sections that require a written response are noted below. All plans should include:

- Detailed steps to be taken to make improvements
- Target dates for completion.
- Submitted to DPBHS for review and approval no later than thirty (30) calendar days from receipt of this report.

Performance Improvement Plan (PIP): Requires a written explanation of what the agency will do to make the specified correction. Areas with a score between 75% & 89% require a Performance Improvement Plan.

**Areas that require a Performance Improvement Plan:**

Corrective Action Plan (CAP):

- Areas with scores of 50%-74% or Average Compliance require a thorough written explanation of what the agency will implement to make the specified correction as well as how they will evaluate and review information to ensure that the plan was effective.
- Areas with scores of 0%-49% or No – Low Compliance require both a thorough written explanation of what the agency will implement to make the specified correction as well as how they will evaluate and review information to ensure that the plan was effective and for the agency to outline time frames where they will provide DPBHS Quality Improvement Unit with data and findings on the progress of implementing the recommendations.

**Areas that require a written Corrective Action Plan:**

If a performance improvement plan or corrective action plan is required, follow up will be coordinated by the DPBHS Quality Improvement Unit. Follow up visits will occur every 6-8 weeks until full compliance with the submitted and approved response is reached. Our goal is to assist providers in enhancing their service systems by providing feedback that will aide them in maintaining compliance and providing quality mental health services to Delaware children. Please contact the DPBHS Quality Improvement Unit if you have any questions or concerns regarding the information contained in the monitoring report.







**Description of Event: Person(s) involved, situation preceding the event, action taken, outcome:**

**Steps taken to evaluate or treat the child and assure child safety:**

**Steps taken to evaluate or treat the child and assure child safety:**

**If reporting restraint or Seclusion:**

**Start Time:**

**End Time:**

**What are the implications of the event for change in the child's treatment or case plan?**

**What are the implications of the event for program or policy change(s)?**

**Did event prompt a staff retraining?**

**Yes**       **No (Explain below)**

**Is this an event that has or will be reported to the program's licensing agency or accrediting body?**

**Yes**       **No (Explain below)**

**If abuse or neglect by staff is alleged, has involved staff been removed from the direct child care setting?**

**Yes**       **No (Explain below)**

CONTACT CATEGORY	NAME	CONTACT (Y / N)	DATE	TIME
Child/Client (for medication error)				
Parent/Guardian				
Foster/Adoptive Parent(s)				
DSCYF Case Manager				
DSCYF Program Administrator or Contract Manager				
DE Abuse Hotline				
DE Office of Child Care Licensing				
Child Protection Agency (other state)				
Police				
Other				
Other				
<b>MOST RECENT CHILD/FAMILY CONTACT INFORMATION</b>				
For events involving a child(ren) occurring in a <u>non-residential service or program</u> only, give the date and description of the provider's most recent contact with the child(ren) prior to this Reportable Event.				
Date of last contact	Time of contact	Person who made the contact	How was the contact made?	
Description of contact:				
<b>PERSON COMPLETING FORM</b>				
I understand that DSCYF has the option of requesting additional and/or periodic written follow-up information regarding corrective actions, administrative investigations, policy or program changes, and/or a written Plan of Safety as a result of this Reportable Event.				
I affirm and attest that all information provided is complete and accurate to the best of my knowledge.				
Printed Name		Title		
Email Address (e-mail address where confirmation of receipt will be sent if submitting electronically)				
Signature (required if NOT submitting electronically)		Date Report Completed	Time Report Completed	
Indicate contact person for additional information if different from above				
<i>Name</i>		<i>Title</i>		<i>Phone Number</i>

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**8.5 SCHEDULE OF DOCUMENT DELIVERABLES - CLINICAL INFORMATION FOR MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES**

# Days Post Admission Rec'd by DPBHS	CLINICAL DOCUMENTATION TO BE SENT TO DPBHS	Reference from Provider Manual	ACUTE CARE PROGRAMS		NON-ACUTE CARE PROGRAMS			
			Crisis	Hosp	RTC **	Day	IOP	BI
5	Provider Certificate of Need Form	5.1.4.3		•				
5	Safety Plan	6.4	•	•	•	•	•	
5	Admission Summary - with physician signature	6.5		•				
15	Admission Summary - with signature of licensed independent practitioner (RTC's must have physician signature)	6.5			•	•	•	
30	Comprehensive Treatment Plan, or Behavioral Intervention Program Plan.	6.6		•	•	•	•	•
10 days post admission to new LOC within same agency	Updated/Revised Treatment Plan	8.1.3		•	•	•	•	•
24 hours after discharge	Transfer Instruction Sheet	6.9.4	•	•	•	•	•	•
7 Days after discharge	Discharge Summary	6.9	•	•	•	•	•	•

**\*\* Note:** RTC includes all residential treatment, including individualized residential treatment (IRT) and therapeutic group care.

**ROUTINE OUTPATIENT SERVICES ONLY**

DOCUMENT	OUTPATIENT DOCUMENTATION TO BE SENT TO DPBHS	Reference from Provider Manual	Received at DPBHS
Initial Request for Service Authorization	Admission to Mental Health or Substance Abuse Outpatient Services	5.3	Immediately after 1 <sup>st</sup> Session
Request for Continued Service Authorization	Revised/current Treatment Plan Request for Re-authorization	5.4	By Expiration Date or by use of last units authorized
Discharge	Discharge Form	5.5	Within 18 days after discharge



## **Billing Audit Error Definitions**

### **No Documentation**

- No documentation received for client (nothing received).
- Documentation received for client, but not the date of service or code billed.
- Documentation does not match date of service, but matches the code billed.
- Documentation does not match the date of service.

### **Insufficient documentation**

- Documentation does not have a legible identifier for service (s) provided/ordered. Unable to determine performing provider.
- Documentation is insufficient
- Documentation is illegible
- Signature is missing. Unable to determine performing provider.

### **Medically unnecessary service**

- Documentation does not include a diagnosis that was consistent with the service billed.  
(Medical necessity for service provided is not supported.)

### **Incorrect coding**

- Documentation submitted does not match the code billed.
- Documentation does not support the higher level of Evaluation and Management code billed
- Documentation does not support the number units billed.
- Provider does not follow (CMS) instructions related to the code billed.
- Documentation does not support the modifier used
- Documentation does not support billing without a modifier.
- Provider does not follow (CPT) instructions related to the code billed.
- Documentation does not meet the criteria for the code billed.

### **Other**

- The name on the documentation does not match the provider on review.
- The provider on review cannot bill for the performing provider.



**State of Delaware**



**The Department of Services  
for Children, Youth and  
Their Families**

*Division of Prevention & Behavioral Health Services*

*"Integrating prevention, early intervention and mental health to enhance services for children & families"*

**(302) 633-2600**

**o Office of The Director o**

**Fax: (302) 633-5118**

**SAMPLE RE-PAYMENT LETTER FROM BILLING AUDIT**

Provider Name  
Provider Address

Today's Date

To Whom It May Concern:

On **(date)** The Division of Prevention and Behavioral Health Services (DPBHS) Quality Improvement Unit conducted a monitoring visit at your **(location)** facility. This facility provides **(service type)** to **(service need)** youth.

Billing audits are a standard part of the monitoring visit. During this audit we reviewed the claims you had submitted to DPBHS for payment with your client records. We reviewed **(number of claims reviewed)** claims. Of these a total of **(total of claims with errors)** claims had errors. Please see the chart below for a detailed description.

**(insert chart from report)**

Per your contract, Attachment B, section H and the Provider Manual, Section 2, your facility is required to reimburse DPBHS for billing errors. Therefore you will need to remit payment in the amount of **(insert amount of overpayment)**

**You may remit payment in one of two ways:**

**Option 1:** Pay back the entire overpayment of **( total overpayment amount\$)**. Payment can be made in FULL by check for **(total overpayment amount\$)**.

**Option 2:** Reduce the amount of a future claim by **(total overpayment amount\$)**. You can make this reduction in three reduction payments (see below) or one claim payment reduction of **(total overpayment amount\$)**.

- Payment 1 (1/3 of total payment amount)**
- Payment 2 (1/3 of total payment amount)**
- Payment 3 (1/3 of total payment amount)**

**Payment must be made within 30 days of the date on this letter.**

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**Please contact Jennifer Tse at 302-633-2572 within 30 days of the date of this letter to advise her of how you wish to proceed.**

Please note that without proper documentation, a claim cannot be verified; as a result, the money paid for that claim must be returned. Returning the money paid for these claims resolves only the overpayment. It does not impact any other investigation relating to the particular claims identified on the spreadsheet, nor will it impact any resulting civil, criminal or administrative action undertaken.

If you have any concerns about our billing procedures, or would like training in how to handle future claims, we would be happy to assist you in that manner.

Thank you,

Tyneisha Jabbar-Bey  
Billing Manager  
Phone 302 633-2695

## Corrective Action Plan Compliance

**Provider: Sample Provider Center**

**Service Type: Services type you provide**



**DATE OF MONITORING VISIT: Date of initial visit**

**DATE OF REPORT: Date report initial was created**

**Correct Action Plan received: Date we received your CAP**

**Date of Compliance Visit: Date of CAP visit 1, date of CAP Visit 2, etc**

**Report Date: Date of CAP visit report 1, date of CAP Visit report 2, etc**

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Clinical Chart Reviews: Original Rating Compliance Rating: 83%, Substantial Compliance

	<u>Issues to be addressed</u> <u>Recommendations from your original</u> <u>Monitoring report (in order)</u>	<u>Sample Provider Response</u>	<u>Compliance Yes, No, or Partial</u>
1.	<p>Treatment plans:</p> <ul style="list-style-type: none"> <li>a. Goals should be written in client language</li> <li>b. Should be signed by the client and guardian</li> </ul>	<ul style="list-style-type: none"> <li>a. In 2012 we will be updating the treatment plans to reflect specific treatment goals. These goals will be written in client language and with the client's input. Our Director is taking the lead on updating these treatment plans.</li> <li>b. Client/Guardian Signatures on Treatment Plans- Our staff are responsible for obtaining signatures. If a client or guardian refuses to sign for any reason our clinical staff will document this on the treatment plan. Re-education has already occurred during staff meetings.</li> </ul>	<p><b>Partial Compliance</b></p> <ul style="list-style-type: none"> <li>a. Progress is being made. Long term goals have been written in client language; however, short term goals are not in client language.</li> <li>b. Additionally, one of the three charts was missing signatures or an explanation for why signatures were not present.</li> </ul>

Handout #9

Quality of Care: Original Rating Compliance Rating: 75%, Substantial Compliance

	<u>Issues to be addressed</u>	<u>Sample Provider Response</u>	<u>Compliance Yes, No, or Partial</u>
1.	Maintain a supervision log that is uniform for all licensed and unlicensed clinical staff. The log should reflect individualized supervision and include the name of the supervisor and supervisee	Clinical Supervision- The program directors will maintain a clinical supervision binder that will contain all individual supervision sessions for all social services staff members in order to reflect that if licensed they are receiving once per month individual clinical supervision, and if unlicensed once per week clinical supervision. We created a new clinical supervision tracking template that will go into effect in October, and will include the name of the supervisor and supervisee, date of the meeting, duration of the meeting, and content of material discussed. This template is attached.	<b>Compliant</b>

Incident/Safety Reports: Original Rating Compliance Rating: 43% Low Compliance

	<u>Issues to be addressed</u>	<u>Sample Provider Response</u>	<u>Compliance Yes, No, or Partial</u>
	Reports are frequently missing the notification page.	All incident reports from Sample Provider Center will include: <ul style="list-style-type: none"> <li>i. A notification page;</li> <li>ii. All required client identification information;</li> <li>iii. No cursive writing;</li> <li>iv. All signatures complete with credentialing;</li> <li>v. Restraint and Seclusion Times;</li> <li>vi. Thorough description of the event that took place;</li> <li>vii. Documentation of notification to the CSC/CSMT;</li> </ul>	<b>Compliant</b>

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**Environment of Care: N/A at this time not reviewing**

**Billing audits: Original Rating Compliance Rating: 100%**

\_\_\_\_\_ Your agency is in **FULL COMPLIANCE**. No further CAP visits are required at this time.

\_\_\_\_\_X\_\_\_\_\_ Your agency is in **Partial Compliance**. Agency **IS REMAINING** under Corrective Action Plan (CAP). The Agency must;

\*\*please note if this line is checked well will be conducting another CAP compliance visit in 4-8 weeks.

\_\_\_\_\_ Agency must **COMPLETE** areas where “NO” was found in the Compliance column

\_\_\_\_\_ Agency must continue to work on areas where “progress is being made or Partial” was found in the compliance column

\_\_\_\_\_ Agency is **NOT in Compliance**. Agency must submit a revised CAP to address items noted on the preceding pages.

\*\*please note if this line is checked we will be conducting another CAP compliance visit in 4-8 weeks.

\_\_\_\_\_ Agency must **COMPLETE** areas where “NO” was found in the Compliance column

\_\_\_\_\_ Agency must amend CAP to address;

**Recommendations:**

At our next visit to your facility please be sure to address all of the recommendations you presented in your CAP. Here is a summary of what we will be looking for:

-Both long term and short term goals should be written in client language

-All charts should have parent/guardian signatures.

-Incident reports submitted between the date of our last CAP review and our next CAP visit will be reviewed for Clinical Service team notification.