OKLAHOMA
Mental Health &
Substance Abuse

CONTRACT MONITORING GUIDE

for treatment programs with fixed rate contracts with ODMHSAS

SFY 2026

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Division: Provider Regulation

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Table of Contents

Introduction

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) contracts with a variety of treatment programs to ensure the state's network of behavioral health providers and services is meeting the needs of Oklahomans. Services are funded through a variety of sources, including state appropriations and federal grants. As the state agency responsible for ensuring these public funds are utilized appropriately and efficiently, ODMHSAS conducts regular monitoring of contracted treatment services.

The mission of ODMHSAS is to ***promote healthy communities and provide the highest quality of care to enhance the well-being of all Oklahomans***. The ODMHSAS supports this mission in part by implementing standards and requirements for the highest quality of care within contracts for treatment providers. The ODMHSAS Compliance and Assistance Team carry out this mission through contract monitoring of publicly funded mental health and addiction providers to ensure standards are met and to identify technical assistance needs.

This contract monitoring guide is intended to meet several objectives, including:

- Ensuring appropriate services are being provided,
- Ensuring funding is being utilized for authorized purposes,
- Ensuring performance goals are being achieved; and
- Identifying and addressing needs for technical assistance and training.

This manual is designed to provide important information and guidance regarding the contract monitoring process and the expectations for provider compliance.

Please note the information in this document is subject to change. The manual will be maintained and made publicly available on the ODMHSAS ARC website at:
http://www.odmhsas.org/picis/Documents/arc_Documents.htm

ODMHSAS Contract Monitoring Contact Information

At any time throughout the year, contracted entities may request technical assistance on a contractual issues by contacting the assigned Field Services Coordinator or the Program Manager. Contact information is provided below.

- Wanda Smith, Program Manager: wanda.smith@odmhsas.org
- Jordyn Parr, Field Services Coordinator: jordyn.parr@odmhsas.org
- Kadion Lilly, Field Services Coordinator: kadion.lilly@odmhsas.org
- Heather Brinkman, Field Services Coordinator: heather.brinkman@odmhsas.org

The Contract Monitoring Process

Contract monitoring is comprehensive and consists of various processes, including desk reviews and data analysis.

Desk Reviews

Desk reviews may be performed on a quarterly basis as indicated below, and as deemed necessary by ODMHSAS. The reviewer will notify contractors prior to the review and collect specific documentation relevant to the Boilerplate, Big SOW (Statement of Work), General Substance Abuse Services SOW and Program Specific SOW, as applicable. The review may include, but not be limited to screenings, assessments, treatment plans, progress notes, policy and procedures, and personnel information.

Contractors will submit the requested information via Secure Email (Access Control Portal) or TEAMS, within the specified timeframe negotiated between the Contractor and the reviewer. Once the information is collected, and the reviewer has completed the review, reviewers will then follow the reporting procedures listed in this section.

The process for reviews is as follows:

1. The ODMHSAS reviewer will send an email to the preferred agency contact, informing them of the upcoming review, along with an attached request letter
    a. The letter of request explains the review process, documentation required for submission, and the date documents are due.
2. Once the documentation is submitted on TEAMS or encrypted email, the reviewer begins the review
3. Files are transferred to the agency's individual folders on the ODMHSAS server
4. The ODMHSAS staff utilize the updated contract monitoring tools, based on agency contracts, to complete the review
5. Throughout the review process, the ODMHSAS staff is in communication with the designated agency contact regarding any questions or concerns that arise, including requesting missing documentation, clarification, etc.
6. Final reports are completed and saved to the agency's folders
7. Once the review is completed, ODMHSAS staff reach out to the provider to inform them of the results of the review
    a. For Personnel and Policy review, agencies with no findings are sent an email stating no issues found
    b. For agencies that have findings, a meeting is set up to discuss findings
    c. For Clinical Record review, a meeting via Zoom or TEAMS is scheduled via email at the convenience of the agency to review findings and go over all the review reports. The agencies are then given a period of time to review the reports with

staff if requested and ask for further clarification and/or submit additional documentation. Once received by ODMHSAS, the documentation will be reviewed and reports finalized.

Please see the information below for further details regarding reviews.

- **1st Quarter Review**

During the first quarter of the fiscal year (July-September), the reviewer will ensure policies and procedures are relevant and current according to the ODMHSAS contract boilerplate and program specific statement(s) of work (SOWs). Contractors may be asked to provide evidence of how their agency/facility policy and procedures are being carried out.

In addition, a personnel records review will be conducted. This review is to ensure staff providing clinical services meet specific professional qualifications and that they are current. The reviewer will verify staff credentials, training, and qualifications according to the ODMHSAS boilerplate, SOWs, and Services Manual.

The records and documentation requested will be for the first quarter, though the review may extend to the second quarter.

- **2nd or 3rd Quarter Review**

During the second and/or third quarter of the fiscal year, clinical records will be reviewed, and a service verification will be performed. The reviewer will verify services were individualized, consumer-involved and assessment-driven. Review of clinical documentation may include, but not be limited to, screenings, assessments, treatment plans, corresponding progress notes, and other documentation required per the SOW(s). The reviewer will also review with the Contractor the final reports for clinical records.

The reviewer will also verify services on clinical records that were selected as a part of the clinical records review. A service verification report from PICIS will be generated that will include a random sample of procedure codes billed and paid during the current fiscal year. The report will identify services that do not meet requirements and are subject to recoupment. The report will include the consumer identification, contract source, service dates, rendering provider identification, and the reason(s) services are to be recouped. Once the reports are completed by the reviewer, they are then sent for approval by management.

- **4th Quarter Review**

During the fourth quarter of the fiscal year, the reviewer will continue to monitor contract compliance and follow-up on 2nd and/or 3rd quarter findings, if needed.

Exit Meeting

After the reviewer(s) has completed the desk review, a virtual exit conference will be conducted. During the exit conference, a summary review of the findings will be shared with the Contractor's designated staff, including any suggestions or recommendations for improvement. If the agency has a recoupment, the specific reasons will be discussed. The Contractor will have the opportunity to ask questions and seek clarification during the exit conference. If the Contractor or reviewer(s) identifies a need for technical assistance (TA) during the visit, the reviewer will make arrangements for the provision of TA. The Contractor will be informed that all findings are preliminary and subject to supervisory review and approval.

Final Report

After the contract monitoring review, the Contractor can expect a formal letter/report providing feedback within **thirty (30) business days** of the review detailing the findings of the review and technical assistance recommendations, if necessary. A requirement to submit a plan of correction will be included should there be findings. In the event there were no findings, a letter confirming this will be completed.

The letter/report will be sent via email to the Executive Director and/or an agency designee. A copy of the letter/report with supporting documentation is electronically filed with ODMHSAS.

Plan of Correction

If a plan of correction is warranted, the Contractor must provide a written response within **fifteen (15) calendar days** from the date the Contractor receives the final report and must address all findings. The plan of correction should provide action steps such as specific policy, procedures and/or processes that will be implemented to improve performance by the Contractor and a time frame for implementation of each corrective action.

If the resubmitted response is deemed satisfactory, the Contractor will be notified by the reviewer indicating acceptance of the reply and that no further action is necessary. A submitted response deemed unsatisfactory will result in an email to the Contractor detailing why the response did not meet the minimum requirements and what the Contractor must do to resolve the issue(s), as well as a timeframe for completing these actions.

The reviewer will verify that corrective action has been enacted according to the plan of correction. The nature of the responses and findings of the review will determine whether follow-up documentation is required, or a follow-up visit(s) is necessary to verify that the plan of correction has been enacted.

If the findings are not resolved according to the ODMHSAS contract requirements, the Contractor may be subject to disciplinary action or termination.

Contract Monitoring Process Overview

Desk Review: Policy/Procedures, Personnel Requirements

- Occurs during first and (if needed) second quarter of the fiscal year.

Desk Review: Services Verification/ Clinical Record Review

- Occurs during second and/or third quarter of the fiscal year.

Exit Meeting

- Completed desk review is discussed with the Contractor.

Final Report

- A final report with all findings and recoupment amounts is supplied to the Contractor.

Plan of Correction

- If needed, Contractors have 15 calendar days to submit a plan of correction as indicated in the final report.

Follow-Up (if applicable)

- Verification of items in the plan of correction may be completed.

The Compliance Landscape

Provider Certification

- For most (but not all) provider types, ODMHSAS certification is required by law in order to operate as a provider in the state
- ODMHSAS certification does not guarantee or initiate any payer relationship or contract for services
- Provider Certification focuses on infrastructure and operations, and does NOT involve a review of the billing associated with services provided
- Provider Certification requirements are provided within the ODMHSAS administrative rules for the applicable program

Contract Monitoring

- ODMHSAS purchases certain services with public dollars through contracts when other funding (e.g., Soonercare) is no available
- There are many providers who are ODMHSAS certified but do not contract with ODMHSAS. Only providers that contract with ODMHSAS are subject to a contract monitoring review, though other payers (such as SoonerCare) may have their own contract reviews
- Contract Monitoring focuses on ensuring services billed to ODMHSAS were provided in accordance with ODMHSAS requirements
- Contract Monitoring requirements are provided within contract documents and the ODMHSAS Services Manual

Locating Your Program's Contract Requirements

There are three types of documents that together make up your contract requirements for which contract monitoring will perform a review:

- **Contract Boilerplate** – describes general requirements for all contractors in a broad category
- **Statement of Work** – describes program-specific requirements
- **Services Manual** – describes specific requirements for each billable service, as well as requirements for clinical documentation

Contract Boilerplate

Upon an initial contract with ODMHSAS, the program will receive the full boilerplate contract language for the applicable contract type. Subsequently, the program may receive a list of any changes to the boilerplate language at each renewal. For questions regarding these documents, please contact ODMHSAS Contract Monitoring.

Please note that the boilerplate language may reference other applicable policies, such as state statute, federal regulations, or grant requirements, for which the program must also maintain compliance.

Statement of Work (SOW)

Each type of program has a statement of work that lists a number of requirements regarding the program's infrastructure, personnel, services, and other elements. Part of the contract monitoring review is ensuring that the program-specific requirements in this statement of work are in place. Most providers will have multiple Statements of Work, including the "Big SOW" for mental health providers and the "General SUD Services" for addiction providers.

Statements of work for each program type are available at: http://www.odmhsas.org/picis/Documents/arc_Documents.htm.

Please note that your statement of work may reference other applicable policies, such as state statute, federal regulations, or grant requirements, for which the program must also maintain compliance.

Instructions for finding your Statement of Work (SOW) on the ODMHSAS ARC website:

- *Under the Documents tab, click the arrow next to Statements of Work*

- Providing-Billing Services that Suppor
- PRSS Protocol for Provision of ODMHS
- BH Case Management Guide

Opioid Treatment Providers

- OTP Providers

Telehealth Resources

- CMS Telehealth Toolkit

ODMHSAS Contracted Agencies Only

- ODMHSAS Service Manual for FY23 -

▶ **Statements of Work**

- *Once expanded, select the current fiscal year and navigate to your applicable SOW. The SOWs match the contract line names in your contract.*

▼ **Statements of Work**

- ▶ FY21 SOWs
- ▶ FY22 SOWs
- ▶ FY23 SOWs
- ▶ FY24 SOWs
- ▼ FY25 SOWs
  - Big SOW
  - Eligibility and Target Population Matrix
  - General SUD Services
  - ▶ Advocacy Services
  - ▶ AFC-STARS
  - ▶ Child, Youth, Young Adults, & Families
  - ▶ Criminal Justice Services
  - ▶ Non-Categorical SOW
  - ▶ Residential Care
  - ▶ Recovery Support Services
  - ▶ System of Care (SOC)

Services Manual

An important part of the contract monitoring review as a treatment provider is services verification, which includes a review of services provided and billed to ensure requirements for those specific services were met. These requirements are listed for each service in the ODMHSAS Services Manual available at: http://www.odmhsas.org/picis/Documents/arc_Documents.htm.

There are a number of elements for which fidelity will be reviewed, including:

- Clinical/treatment requirements – the definition and requirements of the service itself were met
- Staff requirements – the service was provided by staff who met all requirements
- Documentation requirements – the service was documented in accordance with all requirements

ODMHSAS regularly updates this manual to reflect billing system changes, rate changes, policy changes, and other clarifications to service expectations. It is important for programs to ensure that the current version of this document is being referenced in preparation for the contract monitoring review. Each time ODMHSAS updates the Services Manual, a list of changes is provided at the end of the document, and the updated version is placed on the webpage above.

Alignment with SoonerCare/OHCA Rules and Requirements

While ODMHSAS contracts and SoonerCare/OHCA requirements are distinct, there is quite a bit of overlap. Both agencies work to align requirements where appropriate in order to simplify compliance requirements for providers. However, each entity has separate regulations and compliance review processes. If your program serves SoonerCare members, please be sure to note the applicable rules and requirements in addition to ODMHSAS rules and requirements.

Please note that ODMHSAS may request SoonerCare client charts for review in addition to ODMHSAS clients. However, any findings noted within SoonerCare charts will result in a recommendation, rather than a recoupment, from ODMHSAS.

Common Findings and Examples

The following is a list of some of the common findings that ODMHSAS Contract Monitoring encounters during reviews.

Staff Qualifications Not Sufficient/Not Documented

1	Provider not qualified to provide service billed
Description	The provider documented as providing the service does not have the qualifications to provide the service as stated in the Services Manual.
Reference	Services Manual: see page that describes exact service(s) billed
Example(s)	An individual rehabilitation service is billed but provided by a Peer Recover Support Specialist (PRSS) as indicated in the corresponding progress note.
Take-Away	Providers of services must meet minimum qualifications for each service in accordance with Services Manual, administrative rules, and individual licensing regulations.

2	No documentation of service provider
Description	The relevant service does not indicate which staff member provided the service.
Reference	Services Manual: see page that describes exact service(s) billed
Example(s)	A screening is performed and completed, but documentation/notation of which provider completed the screening is not present.
Take-Away	For each service provided, documentation or notation of who completed the service must be available. For most services, this is accomplished through a progress note, but if the service does not require a progress note, alternative documentation must be supplied.

Invalid CDC

3	Invalid CDC
Description	There is no valid service plan and/or Customer Data Core (CDC) for the consumer who received the services billed.
Reference	Services Manual: Service Plan, Page 100- 101. Boilerplate: IV.B
Example(s)	The corresponding CDC for a billed service indicates the wrong service code. For instance, a transaction type 21 (pre-admission) CDC is utilized after admission.
Take-Away	Ensure an accurate CDC is completed.

Incomplete Service Plan

4	No service plan
Description	There is no valid service plan and/or Customer Data Core (CDC) for the consumer who received the services billed.
Reference	Services Manual: Service Plan, Page 100- 101, Boilerplate: IV, B
Example(s)	There is no corresponding service plan for the service(s) billed for a consumer, or the CDC expired before the services were provided.
Take-Away	Ensure a complete service plan and current CDC is present.

5	Service plan or service plan update is missing signature, credentials, and/or date
Description	The service plan or service plan update does not include the consumer's signature, the clinician's signature, the clinician's credentials, clinician co-signature (if applicable), and/or dates.
Reference	Services Manual: Service Plan, Page 100- 101.

Example(s)	Service plan has no consumer signature or date. Service plan has the signature of the client and the clinician but has no dates.
Take-Away	The service plan and all service plan updates are not considered complete/valid unless signed and dated by both the consumer and the clinician, including the clinician's credentials.

6	Service plan or service plan update did not list the type and/or frequency of services
Description	The service plan or service plan update does not list type of services to be provided, and/or the frequency of those services.
Reference	Services Manual: Service Plan, Page 100- 101.
Example(s)	The service plan lists the type of services to be provided, but no frequency is indicated.
Take-Away	The service plan or update is not considered complete/valid unless it includes the specifics of the type and frequency of the services to be provided to the consumer during the time period covered by the service plan or update.

7	Service billed not listed in service plan
Description	The service plan or service plan update includes the type and frequency of services to be provided, but the service billed is not listed.
Reference	Services Manual: Service Plan, Page 100- 101.
Example(s)	An individual rehabilitation service is provided to client, but service plan does not indicate that this service will be provided as part of treatment.
Take-Away	All services billed should be represented in the service plan or service plan update. If the type or frequency of services changes, a service plan update with the changes should be completed.

8	Provider's name and/or credentials not listed on service plan
Description	The name and credentials of the staff member(s) who will be providing the services listed within the service plan are not included.
Reference	Services Manual: Service Plan, Page 100- 101.
Example(s)	The service plan lists the type and frequency of services to be provided but does not list the providers who will be providing those services.
Take-Away	All staff who will regularly be providing the services must be listed in the service plan or service plan update. If the providers of the services change, a service plan update or addendum with the changes should be completed.

9	Goal/objective does not match service plan
Description	A goal/objective is listed on a progress note but the goal/objective is not listed on the service plan or service plan update.
Reference	Services Manual: Service Plan, Page 100- 101. Services Manual: Progress Notes, Page 102- 103.
Example(s)	The progress note indicates progress was made towards developing healthy coping skills; however, this is not a goal/objective listed on the consumer's service plan.
Take-Away	The goals/objectives within progress notes must match goals/objectives in the service plan. If the goals/objectives change, a service plan update with the changes should be completed.

Service/Billing Discrepancies and Errors

10	Service billed was not provided according to the progress note
Description	The corresponding progress note for the service billed documents that the service was not provided.
Reference	Services Manual: see page that describes exact service(s) billed

Example(s)	• A drug screen was billed, but the corresponding progress note states that the client did not complete the drug screen. • A group therapy session was billed, but the contents of the corresponding progress note state that the client was a no-show. • An individual therapy session was billed, but the note doesn't describe an individual session but rather a group session.
Take-Away	Progress notes must demonstrate that the service billed was provided.

11	Service not compensable as billed/documented
Description	The corresponding progress note for a billed service does not describe a compensable service as stated in the Services Manual.
Reference	Services Manual: see page that describes exact service(s) billed
Example(s)	• A service was billed, but the corresponding progress note describes an activity that is not compensable. *For example, customer follow-up was billed, but the progress note indicates a voicemail was provided. The progress note describes an activity that is noted as not compensable in the Services Manual.* • A service was billed, but the corresponding progress note describes a different service being provided. For example: *Case management was billed, but the progress note describes intra-agency referral, which does not meet the definition of case management.* *Case management was billed, but the progress note indicates an activity that lasted less than 8 minutes. This service does not meet the definition of case management but rather follow-up.*
Take-Away	Services billed must meet the criteria/description as listed in the Services Manual. Please ensure that each service you provide is documented, AND documented in such a way that ODMHSAS can see that it was provided in a way that meets the service definition and requirements.

12	Units/time billed different than units in note
Description	Units/time of service billed differ from units/time documented on the corresponding progress note.

Reference	Services Manual: Progress Notes, Page 102- 103.
Example(s)	Individual rehabilitation was billed for two hours, but the corresponding progress note documents only one hour of service.
Take-Away	Please ensure the units/time billed match what is documented in the corresponding progress note.

13	Billing date is prior to service date
Description	The corresponding progress note for a billed service is dated after the date billed.
Reference	Services Manual: Progress Notes, Page 102- 103.
Example(s)	An individual therapy session was billed on September 30, but the corresponding progress note indicates the service was provided on October 1.
Take-Away	A service cannot be billed before the date of service as indicated on the progress note.

14	Service billed/provided by different people
Description	The provider indicated on the service claim is not the person who completed the service as indicated on the progress note.
Reference	Services Manual: Progress Notes, Page 102- 103.
Example(s)	Person providing service or overseeing drug screening is not the person whose name appears on the claim.
Take-Away	The service provider must match between billing documentation/claim and the service documentation/progress note.

15	Different consumer name on/in note
Description	The corresponding progress note for a billed service indicates that a different consumer received the service.
Reference	Services Manual: Progress Notes, Page 102- 103.

Example(s)	A case management service was billed for a consumer, but the corresponding progress note indicates a different name as the service recipient.
Take-Away	Please ensure your service claims and corresponding progress notes indicate the correct and same consumer. It is particularly important that progress notes list the correct consumer's name due to privacy/HIPAA regulations.

16	Service can only be billed prior to admission
Description	A service that is defined as a pre-admission service is billed after admission.
Reference	Service Manual: Diagnosis (or Presenting Problem) Related Education-Group, Pg. 51-52.
Example(s)	Diagnosis (or presenting problem) related education group is billed after admission (CDC 23). As defined in the Services Manual, this service can only be billed prior to admission (CDC 21).
Take-Away	Services that are defined as pre-admission services cannot be billed after admission.

17	Time spent completing assessment/service plan is included in event billing but billed separately
Description	Assessments and service plan cannot be billed separately in addition to billing for the assessment/service plan codes.
Reference	Service Manual: Behavioral Health Assessment (Non- MD) pg. 43- 44; Behavioral Health Service Plan (Moderate & Low Complexity) pg. 48- 50.
Example(s)	A progress note for individual therapy indicates an initial ASI was completed. However, the assessment has also been billed as a behavioral health assessment (non-MD).
Take-Away	Assessments and service plans can only be billed/paid as the corresponding code and within certain time periods.

18	Service billed to wrong contract code
Description	Services are billed to the wrong contract code.
Reference	Boilerplate IV, Statement of Work

Example(s)	A service for a 50-year-old consumer is billed to contract code 39AA (Systems of Care). The service code is valid, but the consumer demographics are incorrect.
Take-Away	Ensure services are billed to the correct contract code.

Incomplete Progress Note

19	No progress note for service billed
Description	Progress note for billed service is missing from the chart/documents submitted for review.
Reference	Services Manual: Progress Notes, Page 102- 103.
Example(s)	An individual therapy session was billed, but there is not a corresponding progress note for the service.
Take-Away	Each service provided must have a corresponding progress note in order to demonstrate that the service was provided as billed. Providers should ensure each service billed has a corresponding, complete progress note.

20	No credentials or signature on progress note
Description	The progress note is completed by the service provider but does not include the service provider's signature and/or credentials.
Reference	Services Manual: Progress Notes, Page 102- 103.
Example(s)	A wellness resource skill development service was provided but the progress note does not include a signature or credentials of the service provider.
Take-Away	Progress notes must list the signature and credentials of the service provider.

21	No goal/objective identified in progress note
Description	The progress note does not identify a goal/objective that was addressed by the service.
Reference	Services Manual: Progress Notes, Page 102- 103.

Example(s)	The progress note for a group therapy session indicates that behavior change was discussed but does not indicate a goal/objective that was addressed.
Take-Away	Progress notes must identify a specific goal/objective related to the consumer's service plan for each service provided.

22	No clinician intervention documented in the progress note
Description	The progress note does not indicate a specific treatment modality was utilized.
Reference	Services Manual: Progress Notes, Page 102- 103.
Example(s)	The progress note for individual therapy notes topics discussed but does not note what approach or intervention was utilized.
Take-Away	Progress notes must include the specific clinical/service intervention provided during the service session. This must include the targeted action(s) the clinician/staff took to move the consumer toward achieving the identified service plan goal(s)/ objective(s) during the service session.

23	No progress or barriers documented in the progress note
Description	The progress note does not include any progress made or barriers to progress for the consumer related to the goals/objectives in the service plan.
Reference	Services Manual: Progress Notes, Page 102- 103.
Example(s)	A progress note lists the activities conducted during a peer recovery support service but does not include any progress made or barriers to progress for the consumer.
Take-Away	Progress notes must include progress made during the treatment session, or barriers to progress, for the consumer related to the goals/objectives of treatment.

24	Identical progress notes or documentation
Description	Progress notes are identical for different services provided to the same consumer, or for different consumers receiving a group service.
Reference	Big SOW: 5.1 GSUD: Treatment Services, 5.1

Example(s)	• Progress notes for individual rehabilitation for two different dates of service for the same consumer are identical. • Progress notes for all consumers in a group therapy session are identical.
Take-Away	Service documentation must demonstrate that services are planned and delivered in an individualized manner.

Common Findings that Result in Recoupment

The following is a list of common reasons for which ODMHSAS will recoup regardless of the specific circumstances of the program or services.

Important Note: *The reasons below are not inclusive of all reasons for recoupment but represent the most common reasons.*

Staff Qualifications Not Sufficient/Not Documented

These issues represent situations where staff were not qualified to provide the service billed, or there is no documentation to demonstrate who provided the service. In addition to a billing issue, this may represent a violation of the individual's licensing or certification regulations.

Please see items 1-2 on page 13 for more detailed information and examples.

Incomplete/Inaccurate Service Plan

These items represent situations when the service plan does not contain all necessary elements. All services provided should be aligned with the current service plan, as the service plan is the document that is utilized to direct and monitor treatment.

- No valid service plan and/or CDC.
- Service plan or service plan update is missing signature, credentials and/or date.
- Service plan or service plan update does not list the type and/or frequency of services.

Please see items 4-9 on pages 14-16 for more detailed information and examples.

Service/Billing Discrepancies

These items represent situations where documentation cannot be supplied to demonstrate that the service billed was provided in accordance with ODMHSAS contract requirements (including the service requirements in the Services Manual).

- Documentation cannot be supplied to demonstrate the service billed was provided.
- Documentation cannot be supplied to demonstrate the service billed was provided in alignment with how it was billed (e.g., number or units, consumer name, etc.).
- Documentation cannot be supplied to demonstrate the service billed was provided in accordance with requirements.
- Documentation cannot be supplied to demonstrate a compensable service was provided.

Please see items 10-18 on pages 16-20 for more detailed information and examples.

Incomplete Progress Note

These items represent situations in which the progress note(s) for a billed service is incomplete and fails to demonstrate the service was appropriately provided.

- No progress note for service billed.
- Progress note is missing provider's signature.

Please see items 19-24 on pages 20-22 for more detailed information and examples.

Repeated Findings

There may be instances when ODMHSAS notes a finding in a provider's summary report but makes a recommendation instead of recoupment. If the same issue is found again in subsequent reviews, ODMHSAS may recoup for the issue.

It is important to remember that each finding requires a Plan of Correction indicating how the program will fix the underlying issue. Thus, ODMHSAS may recoup when it appears that the underlying issue has remained unresolved after a Plan of Correction has indicated actions to fix the issue will be completed by the program.

Important Notes Regarding Recoupment

The exact amount that is recouped is dependent upon several factors and may differ based on the program's circumstances. However, the following are the general guidelines that are utilized to determine the final recoupment amount.

Outpatient Providers

- For compliance issues with treatment services that are provided after the service plan is developed, the amount will be based on the billed amount(s) for each applicable service.
- For assessment and treatment plan development services, if not done appropriately all services for the relevant consumer that appear in the Services Verification may be recouped.
- For CCBHCs, the recoupment amount may be netted at the close-out of the fiscal year against the pended amount.
- For CCBHCs, voided claims resulting from a review that affect your PPS payment may also be implemented.

Residential Level of Care Substance Use Disorder Providers

For halfway house, residential treatment, and medically supervised withdrawal management services paid through a bundled per diem rate, the amount recouped will be based on a formula.

- For compliance issues with treatment services that are provided after the service plan is developed, the recoupment amount will be based on the number of compliance issues multiplied by $10.
- For assessment and treatment plan development services not done appropriately, entire days of service may be recouped, up to a maximum of 20% of paid days in the episode.
- For compliance issues related to required documentation of weekly treatment hours, the following applies:
    - For each hour below the required number of weekly treatment hours, a $10 penalty per hour for each week not in compliance will be assessed OR
    - For weeks in which less than 60% of the required treatment hours were provided, entire days of service may be recouped, up to a maximum of 60% of paid days in the episode.
- If required discharge planning is not completed, the last day of service may be recouped.

Assessment Requirements

Participation

- The consumer and family/guardian/treatment advocate, as appropriate, shall be an active participant(s) in the screening and assessment process.

Staff

- All programs shall complete a comprehensive clinical assessment which gathers sufficient information to assist the consumer in developing an individualized service plan. This assessment shall be conducted by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate.

Signatures

- Assessments are not valid until all signatures are completed and dated, including the co-signature if required.
- All signatures must be dated and hand-written. An electronic signature may be used as an alternative if date stamped.
- **Outpatient**
    - The assessment must be signed by the consumer, parent/guardian (if applicable), and the LBHP or licensure candidate.
    - The signatures may be included on a signature page applicable to both the assessment and the service plan if the signature page clearly indicates that all signatories consent to and approve of both the assessment and service plan.
        - If a signature page is utilized for both the assessment and the service plan, a co-signature must be present when completed by a licensure candidate. All signatures must include the date of the signature.
        - If the assessment and service plan are completed on different dates, each document must have a separate dated signature/acknowledgement for the consumer, parent/guardian (if applicable), the LBHP/candidate and co-signer (if applicable). It also must designate acknowledgement of participation for the corresponding document.
- **Inpatient or Residential**
    - The assessment must be signed by the consumer, parent/guardian (if applicable), and the LBHP or licensure candidate. **Licensure candidate signatures must be co-signed by a fully licensed LBHP.**
    - The signatures may be included on a signature page applicable to both the assessment and service plan if the signature page clearly indicates that all signatories consent to and approve of both the assessment and service plan.
        - If the assessment and service plan are completed on different dates, each document must have a separate dated signature/acknowledgement for the consumer, parent/guardian (if applicable), the LBHP/candidate and co-signer (if applicable). It also must designate acknowledgement of participation for the corresponding document.

- If not signed separately, assessments must be given to and viewable to consumers upon request. All consumers must be made aware of their right to make such a request.
    - If necessary, to maintain the therapeutic relationship, certain items from the assessment may be omitted or redacted before being supplied to the consumer.

Content

- **Mental Health Providers**
    - The assessment shall include, but not be limited to, information regarding the following elements:
        - Behavioral, including mental health and addictive disorders,
        - Emotional, including issues related to past or current trauma and domestic violence,
        - Physical/medical
        - Social and recreational; and
        - Vocational
- **Substance Use Disorder Providers**
    - All facilities shall assess each consumer for appropriateness of admission to the treatment program. Each presenting consumer for substance use disorder treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six (6) dimensions and each level of care. The ASAM must be administered by an LBHP/candidate. The ASAM will only be available to print for 30 days. After 30 days, a provider may access the list of consumers who have completed the ASAM through the Reports section of PICIS.
    - All programs shall complete a biopsychosocial assessment using Addiction Severity Index (ASI) for adults or the Client Assessment Record (CAR) for youth seventeen (17) and under, which gathers sufficient information to assist the consumer's past and current psychiatric medications.
    - Upon determination of appropriate admission, consumer assessment demographic information should contain but not be limited to the following:
        - Date of initial contact requesting services,
        - Date of the screening and/or assessment,
        - Consumer's name,
        - Gender,
        - Birth date,
        - Home address,
        - Telephone number,
        - Referral source,
        - Reason for referral,
        - Emergency contact, and
        - PICIS intake data core content if the facility reports on PICIS.
    - Children accompanying a parent into treatment
        - Assessments of children (including infants) accompanying their parent into treatment (residential or halfway house levels of care) who are receiving services from the facility shall include the following items:
            - Parent-child relationship

        - Physical and psychological development
        - Educational needs
        - Parent related issues
        - Family issues related to the child
    - Assessments of the parent bringing their children into treatment shall include the following items:
        - Parent skills (especially in consideration of the child's issues)
        - Knowledge of age-appropriate behaviors
        - Parental coping skills
        - Personal issues related to parenting
        - Family issues as related to the child
- **Gambling Treatment Providers**
    - Each consumer for gambling disorder treatment shall be assessed using the CAR/ASI and the PGSI (Problem Gambling Severity Index)
        - The CAR should be used for consumers without substance use issues
        - The ASI (for adults) or CAR (for youth seventeen and under) should be used for consumers with substance use issues

Timeframes

The facility shall have policy and procedure specific to each program which dictate timeframes by when assessments must be completed and documented. For consumers admitted to residential or halfway house programs, the assessment shall be completed during the admission process, not to exceed forty-eight (48) hours after admission procedures are initiated.

STRENGTHS-BASED CASE MANAGEMENT ASSESSMENT

All programs providing case management services shall complete a strengths-based case management assessment for the purpose of assisting in the development of an individual plan of care which shall include evidence that the following were evaluated:

- Consumer's level of functioning within the community,
- Consumer's job skills and potential; and/or educational needs,
- Consumer's strengths and resources,
- Consumer's present living situation and support system,
- Consumer's use of substances and orientation to changes related to substance use,
- Consumer's medical and health status,
- Consumer's needs or problems which interfere with the ability to successfully function in the community, and
- Consumer's goals.

Service Plan Requirements

The consumer and family, as appropriate, shall be an active participant(s) in the treatment plan process.

Staff:

- All programs shall complete a comprehensive clinical assessment which gathers sufficient information to assist the consumer in developing an individualized service plan. This assessment shall be conducted by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate.

Signatures:

- The service plan and/or service plan addendum must be signed by the consumer, parent/guardian (if applicable), and the LBHP or licensure candidate. Licensure candidate signature must be co-signed by a fully licensed LBHP.
- The signature page clearly indicates that the signatories' consent and approve of both the assessment and service plan.
    - If the assessment and service plan are completed on different dates, each document must have a separate dated signature/acknowledgment of the consumer, parent/guardian (if applicable), the LBHP/candidate and co-signer (if applicable). It also must designate acknowledgment of participation for the corresponding document.
- All signatures must be dated and hand-written. An electronic signature may be used as an alternative if date stamped.
- The service plan and/or service plan addendum is not considered valid until all of the required signatures/dates are on the service plan/addendum.

Content:

- Initial Comprehensive service plan should address the following:
    - Consumer strengths, abilities, and preferences,
    - Identified presenting challenges, needs, and diagnosis,
    - Goal for treatment with specific, measurable, attainable, realistic, and time-limited objectives,
    - Type and frequency of services to be provided,
    - Description of consumer's involvement in, and response to, the service plan,
    - The practitioner(s) name and credentials who will be providing the services identified in the service plan,
    - Specific discharge criteria, and
    - Dated signature of the consumer, parent/guardian (if applicable), and the LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully licensed LBHP. Signatures must be obtained after the service plan is completed.
- Service plan updates should address the following:

- Progress on previous service plan goals and/or objectives,
- A statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan,
- Change in goals and/or objectives based upon consumer's progress or identification of new needs, and challenges,
- Description of consumer's involvement in, and response to, the service plan update,
- Change in practitioner(s) who will be responsible for providing services on the plan and credentials,
- Change in discharge criteria, and
- Dated signatures of the consumer, parent/guardian (if applicable), and the LBHP or licensure candidate. Licensure candidate signature must be co-signed by a fully licensed LBHP.

Signatures:

- If a licensure candidate completes a service plan or service plan update, a fully licensed LBHP must co-sign the plan.
- Signatures must be handwritten and dated or an electronic signature that is dated will be acceptable.
- The service plan is not considered valid until all the required signatures/dates are on the service plan, including the co-signer, if required.

Note:

- If a change is required to add a new goal/objective or a new clinician to the service plan, the service plan addendum must be signed/dated by the consumer, parent/guardian (if applicable), and the LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully licensed LBHP, and signatures must be obtained after the service plan addendum is completed.

Progress Note Requirements

Staff:

- The qualified staff who provided the service must complete the progress note.

Signatures:

- Progress notes must include the dated signature and credential of the staff who provided the service.

Content:

- **Progress notes (non PSR program):**
  - Date
  - Person(s) to whom services were rendered
  - Start and stop time for each timed treatment session or service
  - Signature of the service provider
  - Specific service plan need(s), goals and/or objectives addressed
  - Services provided, including evidence-based treatment modalities, to address need(s), goals and/or objectives.
    - This refers to the specific clinical/service intervention provided by the clinician/ staff during the service session: the targeted action(s) the clinician/staff took to move the consumer toward achieving the identified service plan goal(s)/objective(s) focused on during the service session.
  - Progress or barriers to progress made in treatment as it relates to the goals and/or objectives
  - Any new need(s), goals and/or objectives identified during the session or service
  - Group progress notes must include the number of consumers attending the group.

- **PRS program progress notes:**
  - Date attended, or date(s) attended during the week for a weekly summary note
  - Start and stop time(s)
  - Specific goal(s) for each day attended
  - Specific goal(s) and/or objectives addressed during the day or during the week
  - Type of skills training provided during the day or during the week (including the educational curriculum used)
  - Progress, or barriers to progress, made toward goals and objectives
  - Any new goal(s) or objective(s) identified during the day or during the week
  - Signature of the lead psychiatric rehabilitation practitioner
  - Credentials of the lead psychiatric rehabilitation practitioner.

Time Frames:

- Outpatient staff must document each visit or transaction, except for assessment completion or service plan development, including missed appointments
- Community living program staff shall complete a summary note monthly identifying the name of the person served and the day(s) the person received the service
- Inpatient: nursing service is to document on each shift. Each member of the treatment team shall write a weekly progress note for the first two months and monthly thereafter
- PSR staff must maintain a daily, member sign-in/sign-out record of member attendance and shall write a progress note daily or a summary progress note weekly
- Residential substance use disorder staff must complete a weekly progress note and additionally complete a separate note for each individual therapy session and each individual case management session.

Notes:

- Crisis Intervention Service notes must also include a detailed description of the crisis and level of functioning assessment
- A list/log/sign-in sheet of participants for each group (rehab, PRSS, wellness, psychotherapy, etc.)
  session and the total number of consumers attending the group session and facilitating staff must be maintained
- For medication training and support, vital signs must be recorded in the medical record but are not required on the behavioral health services plan
- Concurrent documentation between the clinician and consumer (progress notes are completed together with the consumer) can be billed as part of the treatment session time but must be documented clearly in the progress notes.

Transition/Discharge Plans

- Transition/discharge plans shall be developed with the knowledge and cooperation of the consumer. A written plan of recommendations and specific referrals for the implementation of continuing care services, including medications, shall be prepared for each consumer.
- Development of the transition/discharge plan shall begin no later than two (2) weeks after admission into residential/inpatient level of care (ASAM Level 3) service setting.

Frequently Asked Questions

Why does ODMHSAS conduct contract monitoring reviews?

As a state agency, ODMHSAS uses federal and state tax dollars to fund certain behavioral health services for eligible individuals. ODMHSAS is obligated to ensure those dollars are being used in accordance with contract requirements for the provision of evidence-based services. When ODMHSAS cannot establish that funds paid were in fact utilized as required based on documentation, recoupment may result as part of the obligation to ensure funds are paid appropriately.

What is the difference between a contract monitoring review and a provider certification review?

Contract monitoring reviews compare services paid with ODMHSAS funds with ODMHSAS contract requirements to determine compliance. Provider certification reviews compare the overall program operations with administrative rules to determine compliance.

Contract monitoring reviews look at services paid by ODMHSAS to contractors to ensure the services were paid in accordance with Boilerplate and Statement of Work documentation contract requirements, by way of personnel and policy review, chart documentation, and quarterly review.

Provider certification reviews are conducted to allow an organization to legally operate in the state as their relevant provider type. Unlike contract monitoring reviews, provider certification reviews are not concerned with how services were paid. Rather, they are done to determine that the organization is in compliance with established requirements overall to provide appropriate and safe services.

What are ways that I can help my program adhere to contract requirements regarding services billed?

You should ensure all services provided are thoroughly and appropriately documented. Clinical documentation is what contract monitoring staff reviews to determine compliance. If this documentation is overly vague, brief, or incomplete, ODMHSAS cannot demonstrate the service was provided as required by contract. If you feel that your agency could use some additional training, you may email any Contract Monitoring staff member and request technical assistance training.

In addition, it is imperative to thoroughly review all current contractual documents and the current Services Manual.

How long do I have to submit the Plan of Correction (POC)?

If a Plan of Correction is warranted, the Contractor must provide a written response within fifteen (15) calendar days from the date on the email and must address all findings indicated.

How long do I have to void charges and submit evidence they were voided?

Following the exit meeting, providers have sixty (60) calendar days to void out any applicable charges and send in verification of such action.

What can I bill under wellness?

Wellness can only be billed when addressing physical health concerns.

What are the approved Addiction Severity Index (ASI) and American Society of Addiction Medicine (ASAM) trainings?

ODMHSAS has approved ASI and ASAM trainings as follows:

ASI

Karen Albig Smith
Continuing Education Director Program
Services Continuing Education
www.programservices.org
305-401-4361

ASAM

ASAM eLearning

- ASAM Criteria Foundations Course

The Change Companies®

- The first two modules are required (ASAM I - Multidimensional Assessment and ASAM II - From Assessment to Service Planning and Level of Care)

Note: ODMHSAS in-person ASI/ASAM trainings will be available in the near future. Please reference the Provider Update Page at oklahoma.gov/odmhsas/pup for up-to-date information on approved trainings.

Which electronic Addiction Severity Index (ASI) and American Society of Addiction Medicine (ASAM) tools are approved?

ASI

Providers may use the following ASI electronic tools:

- Gain Instruments - GAIN Coordinating Center (gaincc.org)
- ASI-MV (Addiction Severity Index-Multimedia Version) - Hazelden

ASAM

Outpatient providers who aren't utilizing the ODMHSAS ASAM tool in PICIS may use the ASAM CONTINUUM as an electronic ASAM tool.

Note: ODMHSAS in-person ASI/ASAM trainings will be available in the near future. Please reference the Provider Update Page at oklahoma.gov/odmhsas/pup for up-to-date information on approved trainings.

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