ANNUAL REVIEW PROTOCOL FOR SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES

FISCAL YEAR 2020-2021

AUDITS AND INVESTIGATIONS DIVISION

MEDICAL REVIEW BRANCH

BEHAVIORAL HEALTH COMPLIANCE SECTION

ADA Ver. 11/5/2020

Table of Contents

INTRODUCTION

DHCS is committed to ensuring that every beneficiary has access to high-quality, safe, and reliable service at the right level of care, when it is needed. In pursuit of this goal, the divisions of Medi-Cal Behavioral Health and the Behavioral Health and Audits and Investigations annually update the audit protocol to ensure Mental Health Plans are meeting their obligations with their beneficiaries.

Mental Health Plan obligations are outlined in the mental health plan contract, are codified in regulations, and are periodically updated in information notices.

ENFORCEMENT AND CONSEQUENCES FOR NON-COMPLIANCE/TECHNICAL ASSISTANCE AND TRAINING

This annual update to the DHCS review protocol[1] serves to notify the County Mental Health Plan (MHP), that if the Department determines that an MHP is out of compliance with State or Federal laws and regulations or the terms of the contract between the MHP and the Department, the Department may take any or all of the following actions[2]:

(1) Require that the MHP develop a corrective action plan (CAP). The CAP must include the following information:

a. Description of corrective actions, including milestones
b. Timeline for implementation and/or completion of corrective actions
c. Proposed (or actual) evidence of correction that will be submitted to DHCS
d. Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternate corrective action plan to DHCS.
e. Description of corrective actions required of the MHP's contracted providers to address findings.

(2) Withhold all or a portion of payments due to the MHP from the Department.

(3) Impose civil penalties pursuant to Section 1810.385. See also, MHSUDS Information Notice (IN) No. 18-024

(4) Terminate the contract with the MHP pursuant to Section 1810.323.

(5) Take other actions deemed necessary to encourage and ensure contract and regulatory compliance.

If the Department determines that an action should be taken pursuant to Subsection (b), the Department shall provide the MHP with a written Notice of Noncompliance. The Notice of Noncompliance shall include:

(1) A description of the violation

[1] In accordance with Welfare and Institutions Code (WIC) Section 5614
[2] Pto California Code of Regulations (CCR), Title 9, Chapter 11, Sections 1810.325, 1810.380(b), 1810.385, and WIC Section 14712(e),

(2) A description of any corrective action required by the Department and time limits for compliance.

(3) A description of any and all proposed actions by the Department under this Section or Sections 1810.385 or 1810.323, and any related appeal rights.

The MHP may appeal, in writing:

1. A proposed contract termination to the Department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The Department must grant or deny the appeal within 30 calendar days after receipt of the appeal. In granting an appeal, the Department may take another action available under section 1810.380(b). The MHP may not appeal such sanctions to DHCS. Except for terminations pursuant to section 1810.325(c), the Department must suspend the termination date until the Department has acted on the MHP's appeal.
2. A Notice of Non-Compliance to the Department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The Department must grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. The Department must suspend any proposed action until the Department has acted on the MHP's appeal.

LIST OF ABBREVIATIONS

- 24/7: 24 HOURS A DAY/SEVEN DAYS A WEEK
- APP: AID PAID PENDING
- CCC: CULTURAL COMPETENCE COMMITTEE
- CCPR: CULTURAL COMPETENCE PLAN REQUIREMENTS
- CCR: CALIFORNIA CODE OF REGULATIONS
- C.F.R.: CODE OF FEDERAL REGULATIONS
- CFT: CHILD AND FAMILY TEAM
- CMS: CENTERS FOR MEDICARE AND MEDICAID SERVICES
- CPPP: COMMUNITY PROGRAM PLANNING PROCESS
- DHCS: DEPARTMENT OF HEALTH CARE SERVICES
- DMH: [FORMER] DEPARTMENT OF MENTAL HEALTH (STATE)
- EPSDT: EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
- EPLS/SAM: EXCLUDED PARTIES LIST SYSTEM/SYSTEM OF AWARD MANAGEMENT
- FY: FISCAL YEAR
- ICC: INTENSIVE CARE COORDINATION
- IHBS: INTENSIVE HOME BASED SERVICES
- IMD: INSTITUTION FOR MENTAL DISEASES
- IN: INFORMATION NOTICE
- ITWS: INFORMATION TECHNOLOGY WEB SERVICES
- LEP: LIMITED ENGLISH PROFICIENCY
- LPHA: LICENSED PRACTITIONER OF THE HEALING ARTS
- LPT: LICENSED PSYCHIATRIC TECHNICIAN
- LVN: LICENSED VOCATIONAL NURSE
- M/C: MEDI-CAL
- MCE: MEDICAL CARE EVALUATION
- MCP: MEDI-CAL MANAGED CARE PLAN
- MHP: MENTAL HEALTH PLAN
- MHRC: MENTAL HEALTH REHABILITATION CENTER
- MHS: MENTAL HEALTH SERVICES
- MHSA: MENTAL HEALTH SERVICES ACT
- MOE: MAINTENANCE OF EFFORT
- MOU: MEMORANDUM OF UNDERSTANDING
- N: NON-COMPLIANCE, FINDING OF
- NOABD: NOTICE OF ADVERSE BENEFIT DETERMINATION

- NPPES: NATIONAL PLAN AND PROVIDER ENUMERATION SYSTEM
- OIG LEIE: OFFICE OF INSPECTOR GENERAL'S LIST OF EXCLUDED INDIVIDUALS/ENTITIES
- P: PARTIAL COMPLIANCE
- P&Ps: POLICIES AND PROCEDURES
- PCP: PRIMARY CARE PHYSICIAN
- PHI: PROTECTED HEALTH INFORMATION
- PIP: PERFORMANCE IMPROVEMENT PROJECTS
- PLW: PROFESSIONAL LICENSING WAIVER
- POA: POINT OF AUTHORIZATION
- POS: PERFORMANCE OUTCOMES SYSTEM
- PSC: PERSONAL SERVICES COORDINATOR
- QAPI: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
- QIC: QUALITY IMPROVEMENT COMMITTEE
- RCL: RATE CLASSIFICATION LEVEL
- SD/MC: SHORT-DOYLE/MEDI-CAL
- SMHS: SPECIALTY MENTAL HEALTH SERVICES
- SNF: SKILLED NURSING FACILITY
- STP: SPECIALIZED TREATMENT PROGRAM
- TAR: TREATMENT AUTHORIZATION REQUEST
- TBS: THERAPEUTIC BEHAVIORAL SERVICES
- DEVICE FOR THE DEAD / TEXT TELEPHONE / TELETYPE
- UM/UR: UTILIZATION MANAGEMENT/ UTILIZATION REVIEW
- WIC: WELFARE AND INSTITUTIONS CODE
- Y: YES – IN-COMPLIANCE
- TDD/TTY: TELECOMMUNICATION

Category 1: Network Adequacy and Availability of Services

1.1: AVAILABILITY OF SPECIALTY MENTAL HEALTH SERVICES

1.1.1: The MHP shall provide, or arrange and pay for, the following medically necessary covered Specialty Mental Health Services (SMHS) to beneficiaries:

- Mental health services;
- Medication support services;
- Day treatment intensive;
- Day rehabilitation;
- Crisis intervention;
- Crisis stabilization;
- Adult residential treatment services;
- Crisis residential treatment services;
- Psychiatric health facility services;
- Intensive Care Coordination (for beneficiaries under the age of 21);
- Intensive Home Based Services (for beneficiaries under the age of 21);
- Therapeutic Behavioral Services (for beneficiaries under the age of 21);
- Therapeutic Foster Care (for beneficiaries under the age of 21);
- Children's crisis residential programs;
- Psychiatric Inpatient Hospital Services; and,
- Targeted Case Management.

(MHP Contract, Ex. A, Att. 2)

Documentation to review

- Policies and Procedures (P&P)
- MHP Implementation Plan
- Program Descriptions on required services
- Service availability data
- Service utilization data
- Executed provider subcontracts contracts for required services
- POS data

1.1.2: The MHP must make SMHS available 24 hours a day, 7 days a week, when medically necessary. (42 C.F.R. § 438.206(c)(1)(iii).)

Documentation to review

- P&P
- Program description for 24/7 services available to beneficiaries
- Program descriptions for pre-crisis/ crisis services
- Subcontracted provider contract for 24/7 services available to beneficiaries

1.1.3: The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. (42 C.F.R. § 438.206(c)(1)(i),CCR, tit. 28 § 1300.67.2.2 (c)(5)(D))
NOTE: Non-urgent and Non-physician appointments are monitored through the Network Adequacy data submission process. Triennial review will focus on timeliness of all urgent appointments and physician appointments.

- Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment
- Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment

Documentation to review

- P&P
- Service Request Log
- Timeliness compliance monitoring data/report
- Corrective Actions taken to improve timely access to care and services

1.1.4: The MHP shall implement mechanisms to assess the accessibility of services within its service delivery area. This shall include:

1. The assessment of responsiveness of the MHP's 24-hour toll-free telephone number,
2. Timeliness of scheduling routine appointments,
3. Timeliness of services for urgent conditions, and,
4. Access to after-hours care.

(MHP Contract, Ex. A, Att. 8)

Documentation to Review

- P&P
- 24-7 access line monitoring data
- Corrective Action taken to improve accessibility of services
- Timeliness compliance monitoring data/report

1.1.5: The MHP shall require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the MHP shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the MHP, or another MHP. (42 C.F.R. § 438.206(c)(1)(ii).)
Documentation to review

- P&P
- Subcontracted provider contract boilerplate (Excerpts only) with hours of operation requirements

1.1.6: The MHP shall establish mechanisms to ensure that network providers comply with the timely access requirements. (42 C.F.R. § 438.206(c)(1)(iv).)

1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements. (42 C.F.R. § 438.206(c)(1)(v).)
2. The MHP shall take corrective action if there is a failure to comply with timely access requirements. (42 C.F.R. § 438.206(c)(1)(vi).)

Documentation to Review

- P&P
- Service Request Log including subcontractor's data
- Timeliness compliance monitoring data/report
- Corrective Actions taken to improve timely access to care and services
- Evidence the MHP is monitoring timely access (Tracking tools, database, etc.)
- Provider contract boilerplate requiring compliance with timely access standards

1.2 CHILDREN'S SERVICES

1.2.1: The MHP must provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) to all children and youth who meet medical necessity criteria for those services. Membership in the Katie A. subclass is not a prerequisite to receiving ICC and IHBS. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

Documentation to review

- P&P
- ICC/IHBS service criteria
- ICC/IHBS screening tool
- ICC/IHBS training materials
- List of beneficiaries receiving ICC/IHBS
- Referral forms
- Referral tracking mechanisms/logs of children/youth including those who are receiving ICC/IHBS
- POS data

1.2.2: The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need ICC and IHBS. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

Documentation to review

- P&P
- ICC/IHBS service criteria
- ICC/IHBS screening tool
- ICC/IHBS training materials
- List of beneficiaries receiving ICC/IHBS
- Referral forms

- Referral tracking mechanisms/logs of children/youth including those who are receiving ICC/IHBS

1.2.3: The MHP must maintain and monitor network of appropriate providers that is supported by written agreements and is sufficient to provide access to ICC and IHBS services for all eligible beneficiaries, including those with limited English proficiency. (42 C.F.R. § 438.206(b)(1).)
Documentation to review

- P&P
- ICC/IHBS provider subcontracts
- ICC/IHBS provider capacity monitoring data/report
- POS data

1.2.4: The Child and Family Team (CFT) composition always, as appropriate, includes a representative of the MHP and/or a representative from the mental health treatment team. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)
Documentation to review

- P&P
- CFT minutes
- CFT sign-in sheets//Evidence of list of attendees
- CFT training materials
- CFT tracking mechanism/log

1.2.5: The MHP convenes a CFT for children and youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child welfare or juvenile probation systems. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)
Documentation to review

- P&P
- CFT minutes
- CFT sign-in sheets//Evidence of list of attendees
- CFT training materials
- CFT tracking mechanism/log

1.2.6: There is an established ICC Coordinator, as appropriate, who serves as the single point of accountability. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)
Documentation to review

- P&P
- List of ICC Coordinators
- ICC Coordinator's job description/duty statement
- ICC Coordinator training material

- List of beneficiaries receiving ICC/IHBS and their assigned ICC coordinators
- Sample of medical records indicating ICC coordinator's involvement in strength and needs assessment every 90 days, referral, linkage, monitoring, follow-up activities
- CFT minutes/sign-in sheet or other evidence indicating ICC Coordinator's involvement to make recommendations

1.2.7: The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)
Documentation to review

- P&P
- TFC criteria
- TFC screening tool
- List of beneficiaries receiving TFC
- TFC provider subcontract
- POS data
- TFC training materials

1.2.8: The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)
Document to review

- P&P
- TFC criteria
- TFC screening tool
- List of beneficiaries receiving TFC
- TFC training materials

1.3: THE BRONZAN-MCCORQUODALE ACY (1991 REALIGNMENT) SERVICES

1.3.1: The County uses its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e).)
Documentation to review

- P&P
- IMD program brochures
- Evidence services are provided to the target populations
- IMD provider subcontracts

1.3.2: The MHP is required to cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§

14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009)
Documents to review

- P&P
- IMD program brochures
- Evidence services are provided to the target populations (payment records etc.)
- IMD provider subcontracts

1.3.3: Assertive outreach should make mental health services available to homeless and hard-to-reach individuals with mental disabilities. (WIC §5600.2(d).)
Documents to review

- P&P
- Outreach calendars
- Outreach activities tracking log/reports
- Fliers, outreach posters, sign-in sheets or evidence of list of attendees from community events
- Mobile response unit schedule/calendar
- Evidence of referrals or linkages with other social service agencies/services (e.g., child welfare, homeless shelters, veterans' services, law enforcement, churches, schools etc.)

1.4: PROVIDER SELECTION AND MONITORING

1.4.1: The MHP shall provide a beneficiary's choice of the person providing services to the extent possible and appropriate. (CCR, tit. 9, §1830.225(a) and 42 C.F.R. § 438.3(l).)
Document to review

- P&P
- Beneficiary Handbook
- Change of provider request form
- Change of provider request log with dispositions
- Change of provider request samples

1.4.2: Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide beneficiaries an opportunity to change persons providing outpatient SMHS. (CCR, tit. 9, §1830.225(b).)
Documentation to review

- P&P
- Beneficiary Handbook
- Change of provider request form
- Change of provider request log with dispositions
- Change of provider request samples

1.4.3: The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1).)

Documentation to review

- P&P
- Evidence of written notice
- Template for written notice

1.4.4: The MHP shall certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810.435. (MHP Contract, Ex. A, Att. 8)
Documentation to review

- P&P
- MHP's certification and re-certification protocol/forms
- Evidence of onsite certification/recertification of contracted organizational providers or county owned and operated self-certified providers
- Sample of completed certification documentation
- Mechanism to track certification and re-certification status of providers

1.4.5: The MHP shall monitor the performance of its subcontractors and network providers on an ongoing basis for compliance with the terms of the MHP contract and shall subject the subcontractors' performance to periodic formal review. (MHP Contract, Ex. A, Att. 8)
Documentation to review

- Evidence of subcontractor monitoring
- Monitoring/performance reports
- Provider Subcontracts
- Subcontractor's audit/monitoring tools
- Chart documentation manual
- Chart documentation training material
- Chart audit reports

1.4.6: If the MHP identifies deficiencies or areas of improvement, the MHP and the subcontractor shall take corrective action. (MHP Contract, Ex. A, Att. 8)
Documentation to review

- Corrective Action tracking mechanism/log
- Samples of Corrective Actions taken with outcomes

Category 2: Care Coordination and Continuity of Care

2.1: COORDINATION OF CARE REQUIREMENTS

2.1.1: The MHP shall ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(1).)
Documentation to review

- P&P
- Evidence the MHP formally designated a person(s) or entity(ies) to coordinate care for beneficiaries
- Documentation manual
- Monitoring protocols
- Service brochures
- Sample EHR screen shots
- Duty statements/job description of designated person/entity to coordinate care for beneficiaries

2.1.2: The beneficiary shall be provided information on how to contact their designated person or entity. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(1).)
Documentation to review:

- P&P
- Evidence the MHP formally designated a person(s) or entity(ies) to coordinate care for beneficiaries
- Documentation manual
- Monitoring protocols
- Service brochures
- EHR screen shots
- Duty statements/job description of designated person/entity to coordinate care for beneficiaries

2.1.3: The MHP shall coordinate the services the MHP furnishes to the beneficiary between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, tit. 9 § 1810.415.)
Documentation to review

- P&P
- Sample of medical records showing evidence of discharge planning activities and coordination of care across delivery systems
- Any other evidence the MHP coordinates care and ensures warm hand-offs across delivery systems

2.1.4: The MHP shall coordinate the services the MHP furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in Fee-

for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, tit. 9 § 1810.415.)
Documentation to review

- P&P
- Beneficiary medical records
- Evidence of discharge planning activities
- Any other evidence the MHP coordinates care and ensures warm hand-offs across delivery systems

2.2: EXCHANGE OF INFORMATION

2.2.1: The MHP shall share with the Department or other managed care entities serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(4).)
Documentation to review

- P&P
- Release of Information (ROI) forms
- Sample of completed ROI form
- MOU with MCP

2.2.2: The MHP shall ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(5).)
Documentation to review

- P&P
- Release of Information (ROI) forms
- Sample of completed ROI form
- MOU

2.2.3: The MHP shall ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, subparts A and E, to the extent that such provisions are applicable. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(6).)
Documentation to review

- P&P
- Release of Information (ROI) forms
- Sample of completed ROI form
- MOU
- HIPAA beneficiary informing materials

2.3: COORDINATION OF PHYSICAL AND MENTAL HEALTH CARE

2.3.1: The MHP shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for

beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP. (CCR, title 9, section 1810.415(a).).
Documentation to review

- P&P
- Training agendas and meeting notes showing attendee lists Training materials
- Calendar of training events
- Evidence of consultation with health providers, such as a sample of medical records

2.3.2: When the MHP determines that the beneficiary's diagnosis is not included as a SMHS, or is included but would be responsive to physical health care based treatment, the MHP of the beneficiary shall refer the beneficiary in accordance with state regulations. (CCR, tit.9, § 1810.415(d).)
Documentation to review

- P&P
- MHP to MCP Referral forms
- Sample of completed referral from MHP to MCP
- MHP to MCP referral tracking mechanism/log with outcomes

2.4: MOU WITH MEDI-CAL MANAGED CARE PLANS

2.4.1: The MOU addresses the referral protocol between the MHP and MCP, including:

1) How the MHP will provide a referral to the MCP when the MHP determines that the beneficiary's mental illness would be responsive to physical health care based treatment. (CCR, title 9, section 1810.370(a)(1):
2) How the MCP will provide a referral to the MHP when the MCP determines SMHS covered by the MHP may be required. (CCR, title 9, section 1810.370(a)(1):

Documentation to review

- P&P
- MHP to MCP/ MCP to MHP Referral forms
- Sample of completed referral between MHP and MCP
- MHP to MCP and MCP to MHP referral tracking mechanism/log with outcomes
- MOU

2.4.2: The MHP has a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved. (CCR Title 9 § 1810.370(a)(5)).
Documentation to review

- P&P
- MOU
- Dispute tracking mechanism/log with disposition
- MHP and MCP meeting minutes addressing dispute

2.5: CONTINUITY OF CARE

2.5.1: The MHP must establish continuity of care procedures in accordance with MHSUDS IN 18-059. The procedures must address the following requirements:

- Beneficiaries with pre-existing provider relationships who make a continuity of care request to the MHP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (e.g., an employee of the MHP or a contracted organizational provider, provider group, or individual practitioner);
- SMHS shall continue to be provided, at the request of the beneficiary, for a period of time, not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the MHP, in consultation with the beneficiary and the provider, and consistent with good professional practice;
- A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to the MHP for continuity of care;
- Beneficiaries may request continuity of care in person, in writing, or via telephone and shall not be required to submit an electronic or written request; and,
- The MHP must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services. (MHSUDS IN 18-059)

Documentation to review

- P&P
- Sample of continuity of care requests
- Continuity of care request tracking mechanism/log
- Evidence of notification to beneficiaries
- Continuity of care request data/monitoring report

2.5.2: Following identification of a pre-existing relationship with an out-of-network provider, the MHP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the beneficiary. (MHSUDS IN 18-059)

Documentation to review

- P&P
- Sample of contract, letter of agreement, single-case agreement, etc.
- Sample of continuity of care requests
- Continuity of care request tracking mechanism/log
- Evidence of notification to beneficiaries
- Continuity of care request data/monitoring report

2.5.3: Each continuity of care request must be completed within the following timelines:

- Thirty calendar days from the date the MHP received the request;

  - Fifteen calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
  - Three calendar days if there is a risk of harm to the beneficiary. (MHSUDS IN 18-059)

Documentation to review

- P&P
- Sample of continuity of care requests
- Continuity of care request tracking mechanism/log
- Evidence of notification to beneficiaries
- Continuity of care request data/monitoring report

2.5.4: If the provider meets all of the required conditions and the beneficiary's request is granted, the MHP must allow the beneficiary to have access to that provider for a period of up to 12 months, depending on the needs of the beneficiary and the agreement made between the MHP and the out-of-network provider. (MHSUDS IN 18-059)
Documentation to review

- P&P
- Sample of contract, letter of agreement, single-case agreement, etc.
- Sample of continuity of care requests
- Continuity of care request tracking mechanism/log
- Evidence of notification to beneficiaries
- Continuity of care request data/monitoring report

2.5.5: When the continuity of care agreement has been established, the MHP must work with the provider to establish a Client Plan and transition plan for the beneficiary. (MHSUDS IN 18-059)
Documentation to review

- P&P
- Sample of contract, letter of agreement, single-case agreement, etc.
- Sample of continuity of care requests
- Continuity of care request tracking mechanism/log
- Evidence of notification to beneficiaries
- Continuity of care request data/monitoring report
- Sample of medical record indicating client plan and transition plan

2.5.6: Upon approval of a continuity of care request, the MHP must notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:

1) The MHP's approval of the continuity of care request;
2) The duration of the continuity of care arrangement;
3) The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and,
4) The beneficiary's right to choose a different provider from the MHP's provider network. (MHSUDS IN 18-059)

Documentation to review

- P&P
- Sample of continuity of care requests
- Continuity of care request tracking mechanism/log
- Evidence of notification to beneficiaries
- Continuity of care request data/monitoring report

2.5.7: The written notification to the beneficiary must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:

- The MHP's denial of the beneficiary's continuity of care request;
- A clear explanation of the reasons for the denial;
- The availability of in-network SMHS;
- How and where to access SMHS from the MHP;
- The beneficiary's right to file an appeal based on the adverse benefit determination; and,
- The MHP's beneficiary handbook and provider directory. (MHSUDS IN 18-059)

Documentation to review

- P&P
- Sample of continuity of care requests
- Continuity of care request tracking mechanism/log
- Evidence of notification to beneficiaries
- Continuity of care request data/monitoring report
- Beneficiary notification template

2.5.8: The MHP must notify the beneficiary, and/or the beneficiary's authorized representative, 30 calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. (MHSUDS IN 18-059)

Documentation to review

- P&P
- Sample of continuity of care requests
- Continuity of care request tracking mechanism/log
- Evidence of notification to beneficiaries
- Continuity of care request data/monitoring report
- Beneficiary notification template

Category 3: Quality Assurance and Performance Improvement

3.1: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

3.1.1: The MHP has a written description of the Quality Assessment and Performance Improvement (QAPI) Program that:

1. Clearly defines its structure and elements,
2. Assigns responsibility to appropriate individuals, and
3. Adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement.

(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(a)(e)(2).)
Documentation to review

- P&P
- QAPI Program Description

3.1.2: The MHP evaluates the impact and effectiveness of the QAPI Program annually and updates the Program as necessary. (MHP Contract, Ex. A, Att. 5; CCR, title 9, section 1810.440(a)(6).)
Documentation to review

- P&P
- Annual QAPI Program Evaluation

3.1.3: The MHP shall conduct performance-monitoring activities throughout the MHP's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(a)(e)(2).)
Documentation to review

- P&P
- QAPI work plan
- QAPI work plan evaluation
- Evidence of performance monitoring
- Performance data reports

3.1.4: The MHP shall have mechanisms to detect both underutilization and overutilization of services. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(b)(3).)
Documentation to review:

- P&P
- QAPI Work Plan
- Utilization data reports
- EQRO Reports

3.1.5: The MHP has mechanisms to assess beneficiary/family satisfaction by surveying beneficiary/family satisfaction at least annually. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- Annual Beneficiary/Family Satisfaction survey questions sample
- Survey Results

3.1.6: The MHP has mechanisms to assess beneficiary/family satisfaction by evaluating beneficiary grievance, appeals and fair hearings at least annually. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QIC agenda/minutes
- Analysis of grievances, appeals, and fair hearings
- QAPI work plan evaluation

3.1.7: The MHP shall inform providers of the beneficiary/family satisfaction activities. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- Sample notification to providers
- Beneficiary/family satisfaction survey reports

3.1.8: The MHP shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be:

1. Under the supervision of a person licensed to prescribe or dispense medication.
2. Performed at least annually.
3. Inclusive of medications prescribed to adults and youth.

(MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- Prescribing practice guidelines
- Medication practice monitoring tools
- Medication practice monitoring results/report
- Medication practice training materials

3.1.9: The MHP has mechanisms to address meaningful clinical issues affecting beneficiaries system-wide. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QAPI work plan
- QAPI work plan evaluation
- QIC agenda/minutes
- Clinical performance improvement projects
- Corrective action plan or process improvement projects for system-wide improvement

3.1.10: The Contractor has mechanisms to:

1. Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
2. Take appropriate follow-up action when such an occurrence is identified.
3. Evaluate the results of the intervention at least annually.

(MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QAPI Work plan
- QAPI work plan evaluation
- QIC agendas/minutes
- Quality of care concerns monitoring mechanism/tools/log
- Quality of care concern monitoring results

3.2: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN

3.2.1: The MHP has a QAPI Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QAPI Work Plan
- QAPI Work Plan evaluations
- QIC agendas and/or minutes

3.2.2: The QAPI Work Plan includes evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QAPI Work Plan
- QAPI Work Plan evaluations
- QIC agendas and/or minutes

3.2.3: The QAPI Work Plan includes evidence that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QAPI Work Plan
- QAPI Work Plan evaluations
- QIC agendas and/or minutes

3.2.4: The QAPI work plan includes a description of completed and in-process QAPI activities, including:

1) Monitoring efforts for previously identified issues, including tracking issues over time.
2) Objectives, scope, and planned QAPI activities for each year.
3) Targeted areas of improvement or change in service delivery or program design.

(MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QAPI Work Plan
- QAPI Work Plan evaluations
- QIC agendas and/or minutes

3.2.5: The QAPI work plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for:

1) Responsiveness for the Contractor's 24-hour toll-free telephone number.
2) Timeliness for scheduling of routine appointments.
3) Timeliness of services for urgent conditions.
4) Access to after-hours care.

(MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QAPI Work Plan
- QAPI Work Plan evaluations
- QIC agendas and/or minutes
- Accessibility monitoring tools
- Accessibility monitoring results
- Test Call Procedures
- Test Call/Call Answering Services Provider Contracts

3.2.6: The QAPI work plan includes evidence of compliance with the requirements for cultural competence and linguistic competence. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QAPI Work Plan
- QIC agendas and/or minutes
- Cultural Competence Plan

3.3: QUALITY IMPROVEMENT COMMITTEE (QIC)

3.3.1: The MHP shall establish a QIC to review the quality of SMHS provided to beneficiaries.
Documentation to review

- P&P
- QIC Charter
- QIC agendas/minutes

- QIC sign-in sheets/Evidence of list of attendee
- Evidence of planning, design and execution activities

3.3.2: The QIC shall:

a. Recommend policy decisions.
b. Review and evaluate the results of QI activities, including performance improvement projects (PIPs).
c. Institute needed QI actions.
d. Ensure follow-up of QI processes.
e. Document QI committee meeting minutes regarding decisions and actions taken.

(MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QIC Charter
- QIC agendas/minutes
- QIC sign-in sheets/Evidence of list of attendee
- Evidence of planning, design and execution activities

3.3.3: The MHP QAPI program includes active participation by the MHP's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI program. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- Agendas/minutes including list of attendees Evidence of planning, design, and execution activities

3.3.4: The MHP collects and analyzes data to measure against the goals or prioritized areas of improvement that have been identified. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- Data to measure against identified goals
- QIC agenda/minutes
- QAPI Work Plan
- QAPI Work Plan evaluations
- Quality Improvement data reports

3.3.5: The MHP obtains input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- QIC agenda/minutes
- Satisfaction Surveys
- Sample of input received

3.4: UTILIZATION MANAGEMENT

3.4.1: The MHP's Utilization Management (UM) Program shall evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- UM evaluation tools
- UM evaluation and audits results
- Chart audit tools
- Chart audit results/reports
- UMC minutes
- QIC minutes

3.4.2: The MHP shall operate a UM program that is responsible for assuring that beneficiaries have appropriate access to SMHS. (MHP Contract, Ex. A, Att. 5)
Documentation to review

- P&P
- UM evaluation tools
- UM evaluation and audits results
- Chart audit tools
- Chart audit results/reports
- UMC minutes
- QIC minutes

3.5: PRACTICE GUIDELINES

3.5.1: The MHP has practice guidelines, which meet the requirements of the MHP Contract.
(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)
Documentation to review

- P&P
- MHP's Practice Guidelines
- Provider Manual
- Provider Contract Boilerplate
- Practice Guideline Training Materials

3.5.2: The MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.
(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)
Documentation to review

- P&P
- MHP's Practice Guidelines
- Provider Manual

- Provider Contract Boilerplate
- Practice Guideline Training Materials

3.5.3: The MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.
(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)
Documentation to review

- P&P
- MHP's Practice Guidelines
- Provider Manual
- Provider Contract Boilerplate
- Practice Guideline Training Materials

Category 4: Access and Information Requirements

4.1: GENERAL INFORMATION REQUIREMENTS

4.1.1: The MHP shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider. (42 C.F.R. § 438.10(f)(1).)
Documentation to review

- P&P
- Termination notice template
- Sample termination notice to the beneficiaries
- Beneficiary Intake packets addressing termination notice policy

4.2: LANGUAGE AND FORMAT REQUIREMENTS

4.2.1: The MHP shall provide all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 point. (42 C.F.R. 438.10(d)(6)(ii).)
Documentation to review

- P&P
- Beneficiary handbook
- Beneficiary Intake packet

4.2.2: The MHP shall make its written materials that are critical to obtaining services available in the prevalent non-English languages in the county. This includes, at a minimum, the following:

1) provider directories,
2) beneficiary handbooks,
3) appeal and grievance notices,
4) denial and termination notices, and,
5) MHP's mental health education materials,

(MHP Contract, Ex. A, Att. 11; 42 C.F.R. § 438.10(d)(3).)
Documentation to review

- P&P
- Documentation of threshold languages in the county
- Provider Directories
- Beneficiary Handbooks
- Appeal and Grievance notices
- Denial and termination notices
- MHP's mental health education materials (Posted notices and signage, other brochure etc.)

4.2.3: The MHP shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. (MHSUDS IN 18-010E)

Documentation to review
- P&P
- Informing materials with tag line in the threshold languages in the county. Informing materials in large print

4.2.4: The MHP shall notify beneficiaries that written translation is available in prevalent languages free of cost and shall notify beneficiaries how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Cal. Code Regs., tit. 9, § 1810.410, subd. (e), para. (4).)
Documentation to review
- P&P
- Beneficiary Hand book
- Posted informing materials

4.2.5: The MHP has a mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and/or culturally appropriate field testing). (DMH IN No. 10-02)
Documentation to review
- P&P
- Contracts with vendors for translated materials
- Sample of translated materials tested for accuracy

4.3: 24/7 ACCESS LINE AND WRITTEN LOG OF REQUESTS FOR SMHS

4.3.1: The MHP provides training for staff responsible for the statewide toll-free 24-hour telephone line to ensure linguistic capabilities. (CCR, title 9, chapter 11, sections 1810.410 (c) (4)).
Documentation to review
- P&P
- Documentation of training plan
- Training records
- Training materials

4.3.2: Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:
1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.
2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

(CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)
Documentation to review

- DHCS test call worksheets
- P&P
- Contracts/documentation of vendors providing language access for 24/7 statewide toll free line
- Test call scripts
- MHP test call results

4.3.3: The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (CCR, title 9, chapter 11, section 1810.405(f)).
Documentation to review

- P&P
- Written log(s) of initial requests/service request log / access line call log

4.3.4: The written log(s) contain the following required elements:

a) Name of the beneficiary.
b) Date of the request.
c) Initial disposition of the request.

(CCR, title 9, chapter 11, section 1810.405(f).)
Documentation to review

- P&P
- DHCS test call results
- Written log(s) of initial requests/service request log/ access line call log

4.4: CULTURAL COMPETENCE REQUIREMENTS

4.4.1: The MHP has updated its Cultural Competence Plan annually in accordance with regulations. (CCR title 9, section 1810.410)
Documentation to review

- P&P
- Cultural Competence Plan

4.4.2: Regarding the MHP's Cultural Competence Committee (CCC): The MHP has a CCC or other group that addresses cultural issues and has participation from cultural groups that is reflective of the community. (CCR title 9, section 1810.410).
Documentation to review

- P&P
- CCC organizational chart / committee membership roster
- CCC charter
- Cultural Competence Plan
- CCC annual report

4.4.3: The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).
Documentation to review

- P&P
- CCC Annual Report(s)
- Cultural Competence Plan
- QIC minutes

4.4.4: The MHP has evidence of policies, procedures, and practices that demonstrate the CCC activities include the following:

a) Participation in overall planning and implementation of services at the county.
b) Provides reports to the Quality Assurance and/or the Quality Improvement Program.

(CCR title 9, section 1810.410)
Documentation to review

- P&P
- CCC organizational chart
- CCC agenda and minutes
- Cultural Competence Plan
- QIC review documentation
- CCC annual report
- Evidence of CCC reports provided to QIC
- QIC agenda/minutes

4.4.5: Regarding the MHP's plan for annual cultural competence training necessary to ensure the provision of culturally competent services:

1) There is a plan for cultural competency training for the administrative and management staff of the MHP.
2) There is a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP.
3) There is a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing).

(CCR, title 9, § 1810.410 (c)(4).)
Documentation to review

- P&P
- CCC organizational chart
- CCC agenda and minutes
- Cultural Competence Plan
- CCC annual report
- Training records (Administrative and management staff; Persons providing SMHS employed by or subcontracted with MHP)
- Training records for interpreters and bilingual staff
- Training materials/handouts
- Training calendars
- Cultural Competence Training plan

4.4.6: The MHP has evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers. (CCR, title 9, § 1810.410 (c)(4)).
Documentation to review

- P&P
- Documentation of tracking mechanisms to ensure all staff receive required annual training including subcontracted providers
- MHP provider contract

4.4.7: The MHP has a listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by location of the services, pursuant to Section 1810.360 (f)(1). (CCR, Title 9, Section 1810.410 (c)(3), 1810.360 (f)(1))
Documentation to review

- P&P
- List of SMHS and other MHP services available in difference language

4.4.8: The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language (CCR, Title 9, Section 1810.410 (e)(2)(B))
Documentation to review

- P&P
- Sample of referrals made to the provider that have interpreter services in the threshold language

Category 5: Coverage and Authorization of Services

5.1: AUTHORIZATION- GENERAL REQUIREMENTS

5.1.1: The MHP shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(b)(2)(i-ii).)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Utilization Management review tools (chart review tools, inter-rater reliability tools, etc.)
- Approver Licenses and signature list

5.1.2: The MHP shall have any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(b)(3).)

Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Utilization Management review tools (chart review tools, inter-rater reliability tools, etc.)
- Approver Licenses and signature list

5.1.3: The MHP shall notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(c).)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Sample of notification to the beneficiaries

5.1.4: Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e).)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Utilization Management review tools (chart review tools, inter-rater reliability tools, etc.)
- Approver Licenses and signature list

5.1.5: The MHP shall ensure that all medically necessary covered SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. (42 C.F.R., § 438.210(a)(3)(i).)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log

5.1.6: The MHP shall not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary. (42 C.F.R., § 438.210(a)(3)(i).)
Documentation to review

- P&P
- Sample Requests for Authorizations

- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2: CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS

5.2.1: MHPs must establish and implement written policies and procedures addressing the authorization of SMHS. (MHSUDS IN 19-026)

Documentation to review

- P&P
- Sample Requests for Authorization
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.2: MHPs must comply with the following communication requirements:

1) Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
2) Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization.
3) A physician shall be available for consultation and for resolving disputed requests for authorizations;
4) Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting these online;
5) Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,
6) MHPs must provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

(MHSUDS IN 19-026)

Documentation to review

- P&P
- Sample Requests for Authorization
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.3: MHPs are required to conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services.

a. MHPs shall conduct concurrent review of treatment authorizations following the first day of admission.
b. MHPs may elect to initially authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.

(MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.4: Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision.

1) If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination.
2) In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.

(MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Sample of notification to the beneficiary
- Approver Licenses and signature list

5.2.5: In order to conduct concurrent review and authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status.

1) Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.
2) A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.
3) Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

(MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

- Sample of documentation showing required contacts was made
- Mechanisms to ensure proper contacts are made (training material, tracking mechanism/log, desk procedure, check-list etc.)

5.2.6: MHPs must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization.

1) If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization.
2) The MHP must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.

(MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.7: MHPs must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS

a. MHPs may not require prior authorization for the following services/service activities:
    i. Crisis Intervention;
    ii. Crisis Stabilization;
    iii. Mental Health Services -;
    iv. Targeted Case Management;
    v. Intensive Care Coordination; and,
    vi. Medication Support Services.
b. Prior authorization or MHP referral is required for the following services:
    i. Intensive Home-Based Services
    ii. Day Treatment Intensive
    iii. Day Rehabilitation
    iv. Therapeutic Behavioral Services
    v. Therapeutic Foster Care

(MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.8: MHPs must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and

not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. (MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.9: For cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.210(d)(2)).
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.10: The MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that the MHP has authorized. (MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.11: MHPs must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:

  - Retroactive Medi-Cal eligibility determinations;
  - Inaccuracies in the Medi-Cal Eligibility Data System;
  - Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually-eligible beneficiaries; and/or,

Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services). (MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.2.12: In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements. (MHSUDS IN 19-026)
Documentation to review

- P&P
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.3: PRESUMPTIVE TRANSFER

5.3.1: The MHP shall have a comprehensive policy and procedure describing its process for timely provision of services to children and youth subject to Presumptive Transfer. (MHSUDS IN No., 17-032 and 18-027; BH IN No. 19-041)
Documentation to review

- P&P

5.3.2: Upon presumptive transfer, the mental health plan in the county in which the foster child resides shall assume responsibility for the authorization and provision of SMHS and payments for services. (Welf. & Inst. Code § 14717.1(f).)
Documentation to review

- P&P
- Presumptive transfer tracking mechanism/log/report
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.3.3: If the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP in the county in which the foster child resides shall accept that assessment. (Welf. & Inst. Code § 14717.1(f).)
Documentation to review

- P&P

5.3.4: 1) The MHP shall provide evidence of a single point of contact or a unit with a dedicated phone number and/ or email address for the purpose of Presumptive Transfer. (MHSUDS IN No., 17-032)
2) The MHP shall provide evidence the contact information is posted to its public website. (MHSUDS IN No., 17-032)
Documentation to review

- P&P
- Presumptive transfer single point of contact information
- Link to the MHP's website posting presumptive transfer single point of contact information

5.3.5: The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services for children/youth presumptively transferred to the MHP's responsibility. (42 C.F.R. § 438.206(c)(1)(i).)
Documentation to review

- P&P
- Timeliness tracking mechanism/log/report for children/youth presumptively transferred to the MHP's responsibility

5.3.6: The MHP will demonstrate that when there is an exception to Presumptive Transfer and a waiver is in place, the MHP ensures access to services for foster care children placed outside the county of origin. (MHSUDS IN No., 17-032)
Documentation to review

- P&P
- Presumptive transfer waiver tracking mechanism/log/report
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.3.7: In situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, MHPs must provide SMHS immediately, and without prior authorization. (MHSUDS IN No., 18-027)
Documentation to review

- P&P
- Sample of emergent presumptive transfer documentations

5.3.8: Pursuant to (W&I) Code Section 14717.1(b)(2)(F), the MHP has a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction. (MHSUDS IN No., 18-027; W&I Code § 14717.1(b).)
Documentation to review

- P&P
- Sample of expedited transfer documentations
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.3.9: A waiver processed based on an exception to presumptive transfer shall be contingent upon the MHP in the county of original jurisdiction demonstrating an existing contract with a SMHS provider, or the ability to enter into a contract within 30 days of the waiver decision, and the ability to deliver timely SMHS directly to the foster child. That information shall be documented in the child's case plan. (Welf. & Inst. Code § 14717.1(d)(6).)
Documentation to review

- P&P
- Sample of the case documentations showing executed contract within 30 days of the waiver decision

- Presumptive transfer waiver tracking mechanism/log
- Sample Requests for Authorizations
- Payment Authorization Checklist/tools/tracking mechanism/log
- Approver Licenses and signature list

5.4: NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) REQUIREMENTS

5.4.1: The MHP must provide beneficiaries with a NOABD under the following circumstances:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.(42 C.F.R. § 438.400(b)(1))
2) The reduction, suspension or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2))
3) The denial, in whole or in part, of a payment for service. (42 C.F.R. § 438.400(b)(3))
4) The failure to provide services in a timely manner. (42 C.F.R. § 438.400(b)(4))
5) The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (42 C.F.R. § 438.400(b)(5)).
6) The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7))

(MHSUDS IN No. 18-010E)

Documentation to review

- P&P
- NOABD Samples
- NOABD tracking mechanism

5.4.2: The MHP includes the following information in the NOABD:

1. The adverse benefit determination of the MHP has made or intends to make. (42 C.F.R. § 438.404(b)(1)).
2. The reason for the adverse benefit determination. (42 C.F.R. § 438.404(b)(2).
3. The right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 C.F.R. § 438.404(b)(2)).
4. The beneficiary's right to file, and the procedures for exercising, an appeal or an expedited appeal with the MHP, including information about exhausting the MHPs one level of appeal and the right to request a State fair hearing after receiving notice that the adverse benefit determination is upheld. (42 C.F.R. § 438.404(b)(3)-(b)(4))
5. The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5)).
6. The beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under

which a beneficiary may be required to pay the costs of those services. (42 C.F.R. § 438.404(b)(6)).

(MHSUDS IN No. 18-010E)

Documentation to review

- P&P
- NOABD samples
- NOABD templates

5.5: SECOND OPINION

5.5.1: The MHP provides a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b)).

Documentation to review

- P&P
- Sample of second opinion requests and determinations
- Second opinion tracking mechanism/log
- Beneficiary handbook or any other informing materials about second opinion request process

5.5.2: At the request of the beneficiary, when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e)).

Documentation to review

- P&P
- Sample of second opinion requests and determinations
- Second opinion tracking mechanism/log
- Beneficiary handbook or any other informing materials about second opinion request process

5.6: JUDICIAL COUNCIL FORMS

5.6.1: The MHP maintains policies and procedures ensuring an appropriate process for the management of Forms JV 220, JV 220(A), JV 221, JV 222, and JV 223 and that related requirements are met. (Judicial Council Forms, JV 219)

Documentation to review

- P&P
- Sample of JV220 series forms from beneficiary's medical records

Category 6: Beneficiary Rights and Protections

6.1: GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS

6.1.1: The MHP shall have a grievance and appeal system in place for beneficiaries. (42 C.F.R. §§ 438.228(a), 438.402(a); Cal. Code Regs., tit. 9, § 1850.205; MHSUDS IN No. 18-101E) The grievance and appeal system shall be implemented to handle appeals of adverse benefit determinations and grievances, and shall include processes to collect and track information about them. The MHP's beneficiary problem resolution processes shall include:

1) A grievance process;
2) An appeal process; and,
3) An expedited appeal process. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(b)(1)-(b)(3).)

Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials

6.1.2: The MHP shall ensure that each beneficiary has adequate information about the MHP's problem resolution processes by taking at least the following actions:

1) Including information describing the grievance, appeal, and expedited appeal processes in the MHP's beneficiary handbook and providing the beneficiary handbook to beneficiaries. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(1)(A).)
2) Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of adverse benefit determination. For the purposes of this Section, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain specialty mental health services. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, §§ 1850.205(c)(1)(B) and 1850.210.)
3) Make available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all MHP and

network provider sites without having to make a verbal or written request to anyone. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(1)(C).)

4) Give beneficiaries any reasonable assistance in completing the forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(a); 42 C.F.R. § 438.228(a).)

Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials

6.1.3: The MHP shall allow beneficiaries to file grievances and request appeals. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(c)(1).)

Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials

6.1.4: The MHP shall have only one level of appeal for beneficiaries. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a).)

Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials

6.1.5:

1) The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1).)
2) The acknowledgment letter shall include the following (MHSUDS IN18-010E):
   a) Date of receipt

b) Name of representative to contact
c) Telephone number of contact representative
d) Address of Contractor

3) The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN 18-010E)

Documentation to review

- P&P
- Acknowledgement letter template
- Sample acknowledgement letters
- Grievance/Appeal/Expedited Appeal samples
- Grievance and Appeal training materials
- Grievance/Appeal tracking mechanism/log

6.1.6: The MHP shall allow a provider, or authorized representative, acting on behalf of the beneficiary and with the beneficiary's written consent to request an appeal, file a grievance, or request a state fair hearing. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(c)(1)(i)-(ii); Cal. Code Regs., tit. 9, § 1850.205(c)(2).)

Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials

6.1.7: At the beneficiary's request, the MHP shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. (MHP Contract, Ex. A, Att. 12)

Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials

6.1.8: The MHP shall not subject a beneficiary to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(5).)

Documentation to review

- P&P
- Definition of the grievance and appeal

- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials

6.1.9: The MHP's procedures for the beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(6).)
Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials

6.1.10: The MHP shall include a procedure to transmit issues identified as a result of the grievance, appeal or expedited appeal processes to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the Contractor's operations. The MHP shall consider these issues in the MHP's Quality Improvement Program, as required by Cal. Code Regs., tit. 9, §1810.440(a)(5). (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(7).)
Documentation to review

- P&P
- QIC minutes
- Grievance/Appeal/Expedited appeal analysis data/report
- QAPI work plan
- QAPI work evaluation

6.1.11: The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations were not involved in any previous level of review or decision-making, and were not subordinates of any individual who was involved in a previous level of review or decision-making. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(i); 42 C.F.R. § 438.228(a).)
Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials
- Grievance/Appeal/Expedited Appeal samples

- Grievance/Appeal/Expedited Appeal tracking mechanism/log

6.1.12: The MHP shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations, have the appropriate clinical expertise, as determined by DHCS, in treating the beneficiary's condition or disease, if the decision involves an appeal based on a denial of medical necessity, a grievance regarding denial of a request for an expedited appeal, or if the grievance or appeal involves clinical issues. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a).)
Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials
- Grievance/Appeal/Expedited Appeal samples
- Grievance/Appeal/Expedited Appeal tracking mechanism/log

6.1.13: The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).)
Documentation to review

- P&P
- Definition of the grievance and appeal
- Beneficiary handbook
- Problem resolution informing materials
- Problem resolution forms
- Link to the MHP website with problem resolution informing materials
- Grievance and Appeal training materials
- Grievance/Appeal/Expedited Appeal samples
- Grievance/Appeal/Expedited Appeal tracking mechanism/log

6.2: HANDLING GRIEVANCES AND APPEALS

6.2.1: Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1).)
Documentation to review

- P&P
- Grievance/Appeal/Expedited Appeal samples

- Grievance/Appeal/Expedited Appeal tracking mechanism/log

6.2.2: Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person whom the appeal or grievance was filed. (42 C.F.R. § 438.416(b)(1)-(6).)
Documentation to review

- P&P
- Grievance/Appeal/Expedited Appeal samples
- Grievance/Appeal/Expedited Appeal tracking mechanism/log

6.2.3: Record in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log. (Cal. Code Regs., tit. 9, § 1850.205(d)(2).)
Documentation to review

- P&P
- Grievance/Appeal/Expedited Appeal samples
- Grievance/Appeal/Expedited Appeal tracking mechanism/log

6.2.4: Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal. (Cal. Code Regs., tit. 9, § 1850.205(d)(3).)
Documentation review

- P&P
- Grievance/Appeal/Expedited Appeal samples
- Grievance/Appeal/Expedited Appeal tracking mechanism/log

6.2.5: Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the MHP, the provider, and the beneficiary. (Cal. Code Regs., tit. 9, § 1850.205(d)(5).)
Documentation to review

- P&P
- Grievance/Appeal/Expedited Appeal samples
- Grievance/Appeal/Expedited Appeal tracking mechanism/log

6.2.6: Provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. (Cal. Code Regs., tit. 9, § 1850.205(d)(6).)
Documentation to review

- P&P
- Grievance/Appeal/Expedited Appeal samples
- Grievance/Appeal/Expedited Appeal tracking mechanism/log

- Example of provider notification

6.3: Grievance Process

6.3.1: The MHP's grievance process shall, at a minimum: Allow beneficiaries to file a grievance either orally, or in writing at any time with the MHP. (42 C.F.R. § 438.402(c)(2)(i) and (c)(3)(i).)
Documentation to review

- P&P
- Grievance samples
- Grievance tracking mechanism/log

6.3.2: Resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance. (42 C.F.R. § 438.408(a)-(b)(1).)
Documentation to review

- P&P
- Grievance samples
- Grievance tracking mechanism/log

6.3.3: Provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted. (Cal. Code Regs., tit. 9, § 1850.206(c).)
Documentation to review

- P&P
- Grievance samples
- Grievance tracking mechanism/log
- NGR template

6.3.4: Notify the beneficiary of the resolution of a grievance in a format and language that meets applicable notification standards. (42 C.F.R. § 438.408(d)(1); 42 C.F.R. § 438.10.)
Documentation to review

- P&P
- Grievance samples
- Grievance tracking mechanism/log
- NGR template

6.3.5: The MHP shall use a written Notice of Grievance Resolution (NGR) to notify beneficiary of the results of a grievance resolution which shall contain a clear and concise explanation of the Plan's decision. (MHSUDS IN No. 18-010E)
Documentation to review

- P&P
- Grievance samples
- Grievance tracking mechanism/log

- NGR template

6.4: APPEAL PROCESS

6.4.1: The MHP's appeal process shall, at a minimum, allow a beneficiary, or a provider or authorized representative acting on the beneficiary's behalf, to file an appeal orally or in writing. (42 C.F.R. § 438.402(c)(3)(ii).) The beneficiary may file an appeal within 60 calendar days from the date on the adverse benefit determination notice (42 C.F.R. § 438.402(c)(2)(ii).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.2: The MHP treats oral inquiries seeking to appeal an adverse benefit determination as appeals (to establish the earliest possible filing date for the appeal). The MHP requires a beneficiary who makes an oral appeal to subsequently submit a written, signed appeal, unless the beneficiary or the provider requests an expedited appeal. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(c)(3)(ii) and 438.406(b)(3).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.3: Resolve each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal. (42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(2).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.4: Allow the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person and in writing. The MHP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in §438.408(b) and (c) in the case of expedited resolution. (42 C.F.R. § 438.406(b)(4).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.5: Provide the beneficiary and his or her representative the beneficiary's case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon, or generated by the MHP in connection with the appeal of the adverse benefit determination, provided that there is no

disclosure of the protected health information of any individual other than the beneficiary (42 C.F.R. § 438.406(b)(5).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.6: Provide the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.408(b)-(c).)
Documentation review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.7: Allow the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal. (42 CFR § 438.406(b)(6).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.8: The MHP includes in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed. (42 C.F.R. § 438.408(e)(1)).
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log
- NAR template

6.4.9: The MHP includes in the NAR the beneficiary's right to a State fair hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary. (42 C.F.R. § 438.408(e)(2)(i)).
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log
- Beneficiary's right template

6.4.10: The MHP includes in the written notice of the appeal resolution the beneficiary's right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request. (42 C.F.R. § 438.408(e)(2)(ii)).

Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log
- NAR template

6.4.11: The MHP’s expedited appeal process shall, at a minimum:
Be used when the MHP determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, physical or mental health or ability to attain, maintain, or regain maximum function. (42 C.F.R. § 438.410(a).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.12: Allow the beneficiary to file the request for an expedited appeal orally without requiring the beneficiary to submit a subsequent written, signed appeal. (42 C.F.R. § 438.402(c)(3)(ii).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.13: Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. (42 C.F.R. § 438.410(b).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.14: Inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. The Contractor must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal. (42 CFR § 438.406(b)(4); 42 CFR § 438.408(b)-(c).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log
- Example of the informing material

6.4.15: Resolve an expedited appeal and notify the affected parties in writing, as expeditiously as the beneficiary's health condition requires and no later than 72 hours after the Contractor receives the appeal. (42 C.F.R. § 438.408(b)(3).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.16: Provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative. The written notice shall meet the requirements of Section 1850.207(h) of Title 9 of the California Code of Regulations. (42 C.F.R. § 438.408(d)(2); Cal. Code Regs., tit. 9, § 1850.207(h).)
Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.4.17: If the MHP denies a request for an expedited appeal resolution, the MHP shall:

a) Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the Contractor receives the appeal. (42 C.F.R. § 438.410(c)(1).)
b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal.

Documentation to review

- P&P
- Appeal/Expedited Appeal samples
- Appeal/Expedited Appeal tracking mechanism/log

6.5: CONTINUATION OF SERVICES

6.5.1: The MHP must continue the beneficiary's benefits if all of the following occur:

a) The beneficiary files the request of an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
b) The appeal involves the termination, suspension, or reduction of previously authorized services;
c) The services were ordered by an authorized provider;
d) The period covered by the original authorization has not expired; and,
e) The beneficiary timely files for continuation of benefits.

(42 C.F.R. § 438.420(b).)
Documentation to review

- P&P
- Documentation of continued services for beneficiaries pending appeals and/or State Fair Hearings
- Documentation of written notice to beneficiaries, if Aid Paid Pending (APP) criteria are met

6.5.2: If, at the beneficiary's request, the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the following occurs:

a) The beneficiary withdraws the appeal or request for a State Hearing;
b) The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (i.e., NAR) to the beneficiary's appeal;
c) A State Hearing office issues a hearing decision adverse to the beneficiary.

(42 C.F.R. § 438.420(c).)
Documentation to review

- P&P
- Documentation of continued services for beneficiaries pending appeals and/or State Fair Hearings
- Documentation of written notice to beneficiaries, if Aid Paid Pending (APP) criteria are met

6.5.3: If the MHP or the State Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MHP must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 C.F.R. § 438.424(a).)
Documentation to review

- P&P
- State Hearing tracking mechanism/log
- Evidence the MHP authorized or provided services to beneficiaries if the denial was revered

Category 7: Program Integrity

7.1: COMPLIANCE PROGRAM

7.1.1: The MHP has a Compliance program designed to detect and prevent fraud, waste and abuse.
(C.F.R. 42 § 455.1(a)(1) and C.F.R. 42 § 438.608).
Documentation to review

- P&P
- Compliance Plan

7.1.2: The MHP Compliance program includes: Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(1).)
Documentation to review

- P&P
- Compliance Plan
- Standards of conduct template
- Sample of completed and signed acknowledgement of standards of conduct

7.1.3: A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the contract and who reports directly to the MHP Director. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(1).)
Documentation to review

- P&P
- Organizational chart
- Duty statement/job description of Compliance Officer
- Compliance Plan

7.1.4: A Regulatory Compliance Committee (RCC) at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements of this contract. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)
Documentation to review

- P&P
- Compliance Plan
- Organizational Chart
- RCC agendas, minutes, roster
- RCC sign-in sheets/Evidence of list of attendees

7.1.5: A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and

requirements under the contract. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)
Documentation to review

- P&P
- Evidence of completed compliance training, training records
- Compliance training plan
- Compliance training curriculum
- Duty statement/job description of Compliance Officer
- Compliance Training tracking mechanism (log, training record etc.)

7.1.6: Effective lines of communication between the CO and the organization's employees. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)
Documentation to review

- P&P
- Compliance Plan
- Signage/Notice to staff about effective lines of communication with Compliance Officer
- Compliance training materials for staff
- Compliance Hotline information
- Compliance hotline tracking mechanism/log

7.1.7: Enforcement of standards through well publicized disciplinary guidelines. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)
Documentation to review

- P&P
- Compliance Plan
- Disciplinary guideline
- Employee acknowledgement of receipt of disciplinary guideline
- Compliance training material

7.1.8: The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract. (42 C.F.R. §438.608(a)(1).)
Documentation to review

- P&P
- Compliance Plan
- Compliance monitoring and auditing tool
- Compliance Monitoring and auditing results

7.2: FRAUD REPORTING REQUIREMENTS

7.2.1: The MHP, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the MHP for coverage of services and payment of claims under the MHP Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to DHCS about the following:

1) Any potential fraud, waste, or abuse. (42 C.F.R. §438.608(a)(7); MHSUDS IN No. 19-034)
2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. §438.608(a), (a)(2); MHSUDS IN No. 19-034)

Information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MHP. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(4).)

Documentation to review

- P&P
- Compliance Plan
- Compliance monitoring and auditing tools
- Compliance monitoring and auditing results
- Evidence of reporting to DHCS
- Evidence of tracking of overpayments to providers

7.2.2: If the MHP identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying DHCS, the MHP shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed. (MHP Contract, Ex. A, Att. 13)

Documentation to review

- P&P
- Compliance Plan
- Compliance monitoring and auditing tools
- Compliance monitoring and auditing results
- Evidence of tracking of overpayments to providers

7.2.3: The MHP shall implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(6).)

Documentation to review

- P&P
- Compliance Plan
- Compliance monitoring and auditing tools
- Compliance monitoring and auditing results
- Evidence of tracking of overpayments to providers.

7.2.4: The MHP shall implement and maintain arrangements or procedures that include provision for the Contractor's suspension of payments to a network provider for which there is a credible allegation of fraud. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(8).)
Documentation to review

- P&P
- Compliance Plan
- Compliance monitoring and auditing tools
- Compliance monitoring and auditing results
- Evidence of tracking of overpayments to providers

7.3: SERVICE VERIFICATION REQUIREMENTS

7.3.1: The MHP implements and maintains procedures designed to detect fraud, waste and abuse that include provisions to verify services reimbursed by Medicaid were received by the beneficiary. (CCR 42 C.F.R. § 438.608(a)(5).)
Documentation to review

- P&P
- Tools for verifying services were furnished (service verification letter template etc.)
- Evidence of service verification activities (Sample of service verification letter etc.)
- Service verification tracking mechanism/log with outcomes

7.4: DISCLOSURE REQUIREMENTS

7.4.1: The MHP ensures collection of disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the MHP, if applicable, and ensures its subcontractors and network providers submit disclosures to the MHP regarding the network provider's (disclosing entities) ownership and control. (42 C.F.R. Section 455.101 and 104).
Documentation to review

- P&P
- Provider contracts with reporting requirements
- Disclosure monitoring and tracking mechanism/tools/log
- Provider/employee disclosure forms
- Sample of completed provider/employee disclosure forms
- Results of disclosure monitoring activities

7.4.2: As a condition of enrollment, the MHP must require providers to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider. (42 C.F.R. § 455.434(a).)
Documentation to review

- P&P
- Provider contracts with reporting requirements

- Disclosure monitoring and tracking mechanism/tools/log
- Provider/employee disclosure forms
- Sample of completed provider/employee disclosure forms
- Results of disclosure monitoring activities

7.4.3: The MHP requires providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. (42 C.F.R. § 455.434(b)(1) and (2)).
The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104. (MHP Contract, Ex. A, Att. 13)
Documentation to review

- P&P
- Provider contracts with reporting requirements
- Disclosure monitoring and tracking mechanism/tools/log
- Provider/employee disclosure forms
- Sample of completed provider/employee disclosure forms
- Results of disclosure monitoring activities

7.4.4: Disclosures must include:

a) The name and address of any person (individual or corporation) with an ownership or control interest in the network provider.
b) The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;
c) Date of birth and Social Security Number (in the case of an individual);
d) Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);
e) Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or control interest in the same or any other network provider of the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;
f) The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and
g) The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

h) The MHP shall provide DHCS with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from DHCS during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104.

Documents to review

- P&P
- Provider contracts with reporting requirements
- Disclosure monitoring and tracking mechanism/tools/log
- Provider/employee disclosure forms
- Sample of completed provider/employee disclosure forms
- Results of disclosure monitoring activities

7.4.5: The MHP must submit disclosures and updated disclosures to the Department or HHS including information regarding certain business transactions within 35 days, upon request.

1. The ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request.
3. The MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

Documentation to review

- P&P
- Provider contracts with reporting requirements
- Disclosure monitoring and tracking mechanism/tools/log
- Provider/employee disclosure forms
- Sample of completed provider/employee disclosure forms
- Results of disclosure monitoring activities

7.4.6: The MHP shall submit the following disclosures to DHCS regarding the MHP's management:

1. The identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)
2. The identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in 42 Code of Federal Regulations part 455.101.

Documentation to review

- P&P
- Provider contracts with reporting requirements
- Disclosure monitoring and tracking mechanism/tools/log

- Provider/employee disclosure forms
- Sample of completed provider/employee disclosure forms
- Results of disclosure monitoring activities

7.5: DATABASE CHECK REQUIREMENTS

7.5.1: The MHP has a process, at the time of hiring/ contracting, to confirm the identity and exclusion status of all providers (employees, network providers, subcontractors, person's with ownership or control interest, managing employee/agent of the MHP). This includes checking the:

a) Social Security Administration's Death Master File.
b) National Plan and Provider Enumeration System (NPPES)
c) Office of the Inspector General List of Excluded Providers and Entities(LEIE)
d) System of Award Management (SAM)
e) Department's Medi-Cal Suspended and Ineligible List (S&I List). MHP Contract, Ex. A, Att. 13; 42 C.F.R. §§ 438.602(b)(d) and 455.436)

Documentation to review

- P&P
- Reports of database queries from MHP and/or sub-contractors directly checking the database, or utilizing third-party vendors checking the database
- Database check tracking mechanism/logs
- Contract with vendor providing database check service

7.5.2: The MHP has a process to confirm monthly that no providers are on the:

a) OIG List of Excluded Individuals/Entities (LEIE).
b) System of Award Management (SAM) Excluded Parties List System (EPLS).
c) DHCS Medi-Cal List of Suspended or Ineligible Providers (S&I List).

(42 C.F.R. §§ 438.608(d), an 455.436)

Documentation to review

- P&P
- Reports of database queries
- Database check tracking mechanism/logs
- Contract with vendor providing database check service

7.5.3: If the MHP finds a party that is excluded, it must promptly notify DHCS. (42 C.F.R. §438.608(a)(2), (4).

Documentation to review

- P&P
- Evidence of corrective action measures
- Evidence of notification to DHCS

7.6: PROVIDER REQUIREMENTS

7.6.1: The MHP ensures providers of services that require a license, registration or waiver maintain a current license, registration or waiver. (CCR, title 9, section 1840.314(d) and 42 C.F.R. Section 455.412).

Documentation to review

- P&P
- License, registration, waiver tracking mechanism/log
- License, registration, waiver verification reports

7.6.2: The MHP verifies all ordering, rendering and referring providers have a current National Provider Identification (NPI) number. (42 C.F.R. Section 455.440).
Documentation to review

- P&P
- NPI tracking mechanism/log
- NPI verification reports

Category 8: Chart Review- Non-Hospital Services

8.1: MEDICAL NECESSITY

8.1.1: The beneficiary must meet medical necessity criteria outlined in subsections (1-3) to be eligible for services. (CCR, title 9, § 1830.205(b) (outpatient) and 1830.210 (EPSDT), Welf. & Inst. Code § 14132(v) and 14059.5).

1) The beneficiary meets DSM criteria for an included ICD diagnosis for outpatient SMHS in accordance with the MHP contract. (MHSUDS IN Nos., 15-030, 16-016, 16-051, and 17-004E; *BHIN 20-043 released 7/8/2020 with diagnoses tables effective back to 10/1/2019).*
2) The beneficiary must have at least one of the following impairments as a result of the mental disorder or emotional disturbance (listed above in A1): (CCR, title 9, § 1830.205 (b)(2)(A-C).)
    1. A significant impairment in an important area of functioning.
    2. A probability of significant deterioration in an important area of life functioning.
    3. A probability that the child will not progress developmentally as individually appropriate
    4. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate.
3) The proposed and actual intervention(s) meet the intervention criteria listed below: (CCR, title 9, § 1830.205(b)(3)(A), (B), and (C).)
    a) The focus of the proposed and actual intervention(s) addresses the condition identified in No. 1b (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that the SMHS can correct or ameliorate per No. 1 (b)(4).
    b) The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or D):
        A. Significantly diminish the impairment.
        B. Prevent significant deterioration in an important area of life functioning.
        C. Allow the child to progress developmentally as individually appropriate.
        D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.
    c) The condition would not be responsive to physical health care based treatment.

Documentation to review

- P&P
- Beneficiary medical records

8.2: ASSESSMENT

8.2.1: The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation. (MHP Contract, Ex. A, Att. 9)

Documentation to review

- P&P
- Beneficiary medical records

8.2.2: The MHP shall ensure the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed

1) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information.
2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors.
3) History of trauma or exposure to trauma
4) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions.
5) Medical History, including:
    a) Relevant physical health conditions reported by the beneficiary or a significant support person.
    b) Name and address of current source of medical treatment.
    c) For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history.
6) Medications, including:
    a) Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration and medical treatment.
    b) Documentation of the absence or presence of allergies or adverse reactions to medications.
    c) Documentation of informed consent for medications.
7) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs.
8) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s).
9) Risks. Situations that present a risk to the beneficiary and others, including past or current trauma.
10) Mental Status Examination
11) A Complete Diagnosis. A diagnosis from the current ICD-code that is consistent with the presenting problems, history, mental status exam and/or other clinical data; including any current medical diagnosis.

(MHP Contract, Ex. A, Att. 9; CCR, tit. 9, §§ 1810.204 and 1840.112):
Documentation to review

- P&P
- Beneficiary medical records

8.2.3: All entries in the beneficiary record (i.e., Assessments) include:

1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.

5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9)

Documentation to review

- P&P
- Beneficiary medical records

8.3: MEDICATION CONSENTS

8.3.1: The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. (MHP Contract, Ex. A, Att. 9)

Documentation to review

- P&P
- Beneficiary medical records

8.3.2: Written medication consents shall include, but not be limited to, the following required elements:

1) The reasons for taking such medications.
2) Reasonable alternative treatments available, if any.
3) Type of medication.
4) Range of frequency (of administration).
5) Dosage.
6) Method of administration.
7) Duration of taking the medication.
8) Probable side effects.
9) Possible side effects if taken longer than 3 months
10) Consent, once given, may be withdrawn at any time.

(MHP Contract, Ex. A, Att. 9)

Documentation to review

- P&P
- Beneficiary medical records

8.3.3: All entries in the beneficiary record (i.e., Medication Consents) include:

1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9)

Documentation to review

- P&P
- Beneficiary medical records

8.4: CLIENT PLANS

8.4.1: Services shall be provided, in accordance with the State Plan, to beneficiaries who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan.
(MHP Contract, Ex. A, Att. 2)
Documentation to review

- P&P
- Beneficiary medical records

8.4.2: The MHP shall ensure that all medically necessary SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
(MHP Contract, Ex. A, Att. 2)
Documentation to review

- P&P
- Beneficiary medical records

8.4.3: The client plan has been updated at least annually and/or when there are significant changes in the beneficiary's condition. (MHP Contract, Ex. A, Att. 2)
Documentation to review

- P&P
- Beneficiary medical records

8.4.4: The MHP shall ensure that Client Plans:

1) Have specific, observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairment as a result of the mental health diagnosis.
2) Identify the proposed type(s) of interventions or modality, including a detailed description of the intervention to be provided.
3) Have a proposed frequency of the intervention(s).
4) Have a proposed duration of intervention(s).
5) Have interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.
6) Have interventions are consistent with client plan goal(s)/treatment objective(s).
7) Have interventions are consistent with the qualifying diagnoses.

Documentation to review

- P&P
- Beneficiary medical records

8.4.5: Services (i.e., Plan Development) shall be provided within the scope of practice of the person delivering service, if professional licensure is required for the service. Services shall be provided under the direction of one or more of the following:

A. Physician
B. Psychologist

C. Licensed Clinical Social Worker
D. Licensed Marriage and Family Therapist
E. Licensed Professional Clinical Counselor
F. Registered Nurse, including but not limited to nurse practitioners, and clinical nurse specialists
G. Waivered/Registered Professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver.

(CCR, title 9, § 1840.314(e); 1810.440(c); State Plan, Supplement 3, Attachment 3.1-A, pp. 2m-p; MHSUDS IN No. 17-040)
Documentation to review

- P&P
- Beneficiary medical records
- MHP's operational definition of direction
- MHP's scope of practice policies

8.4.6: Client Plans shall be signed (or electronic equivalent) by:
1) the person providing the service(s), or
2) a person representing a team or program providing a services; or
3) a person representing a Contractor providing the services; or
4) by one of the following as a co-signer if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not the approved category;

- A physician
- A licensed waivered psychologist
- A licensed/registered waivered social worker
- A licensed/registered/waivered marriage family therapist
- A licensed/registered/waivered professional clinical counselor, or
- A registered nurse, including but not limited to nurse practitioners and clinical nurse specialists

(CCR, title 9, § 1810.440(c); MHP Contract, Ex. A, Att.9; State Plan, Supplement 3, Attachment 3.1-A, pp. 2m-p; MHSUDS IN No. 17-040)
Documentation to review

- P&P
- Beneficiary medical records
- MHP's operational definition of direction
- MHP's scope of practice policies

8.4.7: The MHP shall ensure that Client Plans include documentation of the beneficiary's participation in and agreement with the Client Plan. (MHP Contract, Ex. A, Att. 9; CCR, title 9, § 1810(c)(2).)
Documentation to review

- P&P

- Beneficiary medical records

8.4.8: The MHP shall ensure that Client Plans include the beneficiary's signature or the signature of the beneficiary's legal representative when:

a) The beneficiary is expected to be in long-term treatment, as determined by the MHP, and,
b) The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS.

(CCR, title 9, § 1810.440(c)(2)(A).)
Documentation to review

- P&P
- Beneficiary medical records
- Definition of long-term care beneficiary

8.4.9: When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan includes a written explanation of the refusal or unavailability of the signature. (CCR, title 9, § 1810.440(c)(2)(B).)
Documentation to review

- P&P
- Beneficiary medical records

8.4.10: The MHP shall have a written definition of what constitutes a long-term care beneficiary. (MHP Contract, Ex. A, Att. 9)
Documentation to review

- P&P
- Beneficiary medical records
- Definition of long-term care beneficiary

8.4.11: There is documentation in the Client Plan that a copy of the Client Plan was offered to the beneficiary.
Documentation to review

- P&P
- Beneficiary medical records

8.4.12: All entries in the beneficiary record (i.e., Client Plans) include:

1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9)
Documentation to review

- P&P

- Beneficiary medical records

8.5: PROGRESS NOTES

8.5.1 The MHP shall ensure that progress notes describe how services provided reduced the impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. (MHP Contract, Ex. A, Att. 9)

Documentation to review

- P&P
- Beneficiary medical records

8.5.2: Items that shall be contained in the client record (i.e., Progress Notes) related to the beneficiary's progress in treatment include all of the following:

1) Timely documentation of relevant aspects of client care, including documentation of medical necessity.
2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions.
3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions.
4) The date the services were provided.
5) Documentation of referrals to community resources and other agencies, when appropriate.
6) Documentation of follow-up care or, as appropriate, a discharge summary
7) The amount of time taken to provide services.
8) The following:
   a) The signature of the person providing the service (or electronic equivalent);
   b) The person's type of professional degree, and,
   c) Licensure or job title.

(MHP Contract, Ex. A, Att. 2)

Documentation to review

- P&P
- Beneficiary medical records

8.5.3: When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, the progress notes shall include:

1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary.
2) The exact number of minutes used by persons providing the service.
3) Signature(s) of person(s) providing the services.

(CCR, title 9, § 1840.314(c).)

Documentation to review

- P&P
- Beneficiary medical records

8.5.4: Progress notes shall be documented at the frequency by types of service indicated below:

1) Every service contact for:
   A. Mental health services
   B. Medication support services
   C. Crisis intervention
   D. Targeted Case Management
   E. Intensive Care Coordination
   F. Intensive Home Based Services
   G. Therapeutic Behavioral Services
2) Daily for:
   A. Crisis residential
   B. Crisis stabilization (one per 23/hour period)
   C. Day treatment intensive
   D. Therapeutic Foster Care
3) Weekly for:
   A. Day treatment intensive (clinical summary)
   B. Day rehabilitation
   C. Adult residential

(MHP Contract, Ex. A, Att. 9; CCR, title 9, §§ 1840.316(a)-(b); 1840.318 (a-b), 1840.320(a-b).)

Documentation to review

- P&P
- Beneficiary medical records

8.5.5: All entries in the beneficiary record (i.e., Progress Notes) include:

1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9)

Documentation to review

- P&P
- Beneficiary medical records

8.6: ICC AND IHBS SERVICES FOR CHILDREN AND YOUTH

8.6.1: The MHP must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs.

(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

Documentation to review

- P&P
- Beneficiary medical records

- ICC/IHBS service criteria
- List of beneficiaries receiving ICC/IHBS

8.6.2: The ICC Coordinator and the CFT reassesses the strengths and needs of children and youth, and their families, at least every 90 days, and as needed. (Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018; MHSUDS IN No. 18-007)
Documentation to review

- P&P
- Beneficiary medical records
- ICC/IHBS service criteria
- List of beneficiaries receiving ICC/IHBS

8.6.3: Claims for ICC must use the following:
1) Procedure code T1017
2) Procedure modifier “HK”
3) Mode of service 15
4) Service function code 07

(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)
Documentation to review

- P&P
- Beneficiary medical records
- ICC/IHBS claim lines

8.6.4: Claims for IHBS must use the following:
1) Procedure code H2015
2) Procedure modifier “HK”
3) Mode of service 15
4) Service function code 57

(Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)
Documentation to review

- P&P
- Beneficiary medical records
- ICC/IHBS claim lines

8.6.5: Each participating provider in a CFT meeting may claim for the time they have contributed to the CFT meeting, up to the length of the meeting, plus documentation and travel time, in accordance with CCR, tit. 9, § 1840.316(b)(3). (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018; MHSUDS IN No. 18-017)

Documentation to review
- P&P
- Beneficiary medical records
- ICC/IHBS claim lines

8.7 LINGUISTICALLY COMPETENT SERVICES

8.7.1: There is evidence that mental health interpreter services are offered and provided, when applicable.
Documentation to review
- P&P
- Sample of beneficiary medical records

8.7.2: If the needs for language assistance is identified in the assessment, there is documentation of linking beneficiaries to culture-specific and/or linguistic services as described in the MHP's CCPR.
Documentation to review
- P&P
- Beneficiary medical records

8.7.3: The MHP shall make its written materials that are critical to obtaining services available to beneficiaries in prevalent non-English languages. (MHP Contract, Ex. A, Att. 11; 42 C.F.R. § 438.10(d).)
Documentation to review
- P&P
- Sample of beneficiary medical records

(This applies to the identified threshold languages of the specific county)

8.7.4: When applicable, treatment specific information was provided to beneficiaries in an alternative format (e.g., braille, audio, large print, etc.). (CCR, title 9, § 1810.410(e)(2), and 3200.210)
Documentation to review
- P&P
- Beneficiary medical records

8.8: DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICES

8.8.1: Day Treatment Intensive (DTI) and Day Rehabilitation (DR) programs include all the following required service components:
A. Daily Community Meetings; *
B. Process Groups (Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.
C. Skill-building Groups; and
D. Adjunctive Therapies;
E. Additionally, Day Treatment Intensive programs also require Psychotherapy.

(MHP Contract, Ex. A, Attachment 2)
Documentation to review

- P&P
- Program Description
- Weekly Schedule
- Beneficiary medical records

8.8.2: Community Meetings shall occur at least once a day to address issues pertaining to the continuity and effectiveness of the therapeutic milieu, and shall actively involve staff and beneficiaries. Community meetings shall include:

a) For day treatment intensive, include a staff person whose scope of practice includes psychotherapy.
b) For day rehabilitation, include a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; and a registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist.

Documentation to review

- P&P
- Program Description
- Weekly Schedule
- Beneficiary medical records

8.8.3: For both DTI and DR, there is a Written Program Description that describes the specific activities of each service and reflects each of the required components described in the MHP Contract.
Documentation to review

- P&P
- Program Description
- Beneficiary medical records

8.8.4: For both DTI and DR, there is an established Mental Health Crisis Protocol, which may be part of the written program description, for responding to beneficiaries experiencing a mental health crisis.

1. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations.
2. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service. (MHP Contract, Ex. A, Attachment 2)

Documentation to review

- P&P
- Program Description
- Mental Health Crisis Protocol

- Beneficiary medical records

8.8.5: For both DTI and DR, the Contractor shall ensure that a Weekly Detailed Schedule is available to beneficiaries and as appropriate to their families, caregivers or significant support persons and identifies when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services. (MHP Contract, Ex. A, Attachment 2)
Documentation to review

- P&P
- Program Description
- Weekly Schedule
- Beneficiary medical records

8.8.6: There is documentation of the total number of minutes/hours the beneficiary actually attended the program each day.
(MHSUDS IN 17-040, CCR, title 9, § 1840.112(b)(6).)
Documentation to review

- P&P
- Program Description
- Weekly Schedule
- Beneficiary medical records

8.8.7: If the beneficiary is unavoidably absent, documentation includes:

A. The total time (number of hours and minutes) the beneficiary actually attended the program.
B. Verification the beneficiary attended for at least 50 percent of the hours of the program operation; **AND**,
C. A separate entry in the medical record documenting the reason for the unavoidable absence.

(MHP Contract, Ex. A, Attachment 2; MHSUDS IN 17-040, CCR, title 9, § 1840.112(b)(6).)
Documentation to review

- P&P
- Program Description
- Beneficiary medical records

8.8.8: When claiming for the continuous hours of operation for Day Treatment Intensive and Day Rehabilitation, the program provides:

1. For Half Day: Face-to-face services a minimum of three hours each program day.
2. For Full Day: Face-to-face services for more than 4 hours per day.

(MHP Contract, Ex. A, Attachment 2; CCR, title 9, § 1810.318)
Documentation to review

- P&P

- Beneficiary medical records

DAY TREATMENT INTENSIVE STAFFING

DTI includes the following staffing (MHP Contract, Ex. A, Attachment 2, CCR, title 9, § 1840.350)

8.8.9: For DTI, at a minimum there must be an average ration of at least one person from the following list to 8 beneficiaries or other clients in attendance during the period the program is open:

(1) Physician
(2) Psychologist or related registered/waivered professional
(3) LCSW or related registered/waivered professional
(4) MFT or related registered/waivered professional
(5) Registered Nurses
(6) Licensed Vocational Nurses
(7) Psychiatric Technicians
(8) Occupational Therapists
(9) Mental Health Rehabilitation Specialists (defined in title 9, section 630)
(10) Persons providing services who do not participate in the entire Day Rehab session, whether full or half-day, shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time they participated in the session.

Documentation to review

- P&P
- Weekly Schedule
- Staffing Schedules
- Beneficiary medical records

8.8.10: For Day Treatment Intensive, staff shall include at least one staff person whose scope of practice includes psychotherapy.

Documentation to review

- P&P
- Beneficiary medical records

8.8.11: The MHP shall ensure there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.

Documentation to review

- P&P
- Beneficiary medical records

8.8.12: If there are more than twelve clients in the Day Treatment Intensive program, staffing shall include at least one (1) staff from the above list.

Documentation to review

- P&P

- Beneficiary medical records

DAY REHABILITATION STAFFING

DR includes the following staffing (MHP Contract, Ex. A, Attachment 2; CCR, title 9, § 1840.352)

8.8.13: For DR, at a minimum there must be an average ratio of at least one person from the following list to 10 beneficiaries or other clients in attendance during the period the program is open:

(1) Physician
(2) Psychologist or related registered/waivered professional
(3) LCSW or related registered/waivered professional
(4) MFT or related registered/waivered professional
(5) Registered Nurses
(6) Licensed Vocational Nurses
(7) Psychiatric Technicians
(8) Occupational Therapists
(9) Mental Health Rehabilitation Specialists (defined in title 9, section 630)
(10) Persons providing services who do not participate in the entire Day Rehab session, whether full or half-day, shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time they participated in the session.

Documentation to review

- P&P
- Weekly Schedule
- Staffing Schedules
- Beneficiary medical records

8.8.14: The MHP shall ensure there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitation services and function in other capacities.

Documentation to review

- P&P
- Beneficiary medical records

8.8.15: If there are more than twelve clients in the Day Rehabilitation program, staffing shall include at least two (2) staff from the above list in 8.8.13.

Documentation to review

- P&P
- Beneficiary medical records

DAY TREATMENT INTENSIVE DOCUMENTATION REQUIREMENTS:

8.8.16: DTI documentation requirements include:

1. Daily Progress Notes on activities attended.
2. Weekly Clinical Summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, marriage and family

therapist, licensed professional clinical counselor or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.

3. Monthly documentation of one contact with family, care-giver, or significant support person identified by an adult beneficiary or one contact per month with the legally responsible adult for a beneficiary who is a minor.
   A. This contact is face-to face or by an alternative method such as email, telephone, etc.
   B. This contact focuses on the role of the support person in supporting the beneficiary's community reintegration.
   C. This contact occurs outside the hours of operation and outside the therapeutic program.

(MHP Contract, Ex. A, Attachments 2 & 9, MHSUDS IN 17-040)
Document to review

- P&P
- Beneficiary medical records

DAY REHABILITATION DOCUMENTATION REQUIREMETNS:

8.8.17: DR documentation requirements include:

1. Weekly Progress Notes.
2. Monthly documentation of one contact with family, care-giver, or significant support person identified by an adult beneficiary or one contact per month with the legally responsible adult for a beneficiary who is a minor.
   A. This contact is face-to face or by an alternative method such as email, telephone, etc.
   B. This contact focuses on the role of the support person in supporting the beneficiary's community reintegration.
   C. This contact occurs outside the hours of operation and outside the therapeutic program.

(MHP Contract, Ex. A, Attachments 2 & 9; MHSUDS IN 17-040)
Document to review

- P&P
- Beneficiary medical records

8.8.18: All entries in the beneficiary's medical record include:

A. The date(s) of service;
B. The signature of the person providing the service (or electronic equivalent);
C. The person's type of professional degree, licensure or job title;
D. The date of signature;
E. The date the documentation was entered in the beneficiary record

(MHP Contract, Ex. A, Attachments 2 & 9; MHSUDS IN 17-040)
Document to review

- P&P
- Sample beneficiary medical records

Category 9: Chart Review- SD/MC Hospital Services

9.1. MEIDCAL NECESSITY

9.1.1: The beneficiary has a current ICD/DSM diagnosis which is included in CCR, title 9, sections 1820.205(a)(1)(A) through 1820.205(a)(R)
(CCR, title 9, § 1820.205(a)(1))
Documentation to review

- P&P
- Beneficiary medical records

9.1.2 : Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode must be considered to have met this criterion. (CCR, title 9, § 1820.205(a)(2)(A); C.F.R. SECTION 456.
Documentation to review

- P&P
- Beneficiary medical records

9.1.3: Requires psychiatric inpatient hospital services, as the result of a mental disorder or emotional disturbance, due to indications in either (a) or (b) below:

a) Has symptoms or behaviors due to a mental disorder or emotional disturbance that (one of the following):
   A. Represents a current danger to self or others, or significant property destruction.
   B. Prevents the beneficiary from providing for, or utilizing food, clothing or shelter.
   C. Presents a severe risk to the beneficiary's physical health.
   D. Represents a recent, significant deterioration in ability to function.

b) Requires admission for one of the following:
   A. Further psychiatric evaluation.
   B. Medication treatment.
   C. Other treatment which could reasonably be provided only if the beneficiary were hospitalized.

(CCR, title 9, § 1820.205(a)(2)(B)(1-2); 42 C.F.R. § 456.170-171)
Document to review

- P&P
- Beneficiary medical records

9.2: CONTINUED STAY SERVICES

9.2.1: The beneficiary's continued stay services in a psychiatric inpatient hospital meets one of the following reimbursement criteria:

1. Continued presence of indications which meet the medical necessity criteria for psychiatric inpatient hospital services. (CCR, title 9, § 1820.205(b)(1).

2. Serious adverse reaction to medication, procedures, or therapies requiring continued hospitalization. (CCR, title 9, § 1820.205(b)(2).
3. Presence of new indications which meet medical necessity criteria for psychiatric inpatient hospital services. (CCR, title 9, § 1820.205(b)(3).
4. Need for continued medical evaluation or treatment that could only have been provided if the beneficiary remained in a psychiatric inpatient hospital. (CCR, title 9, § 1820.205(b)(4).

Documentation to review

- P&P
- Beneficiary medical records

9.3: Administrative day services

9.3.1: If payment has been authorized for administrative day services, the following requirements are met: During the hospital stay, the beneficiary previously met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services. (CCR, title 9, § 1820.230(L)(5)(A).)

Documentation to review

- P&P
- Beneficiary medical records

9.3.2: There is no appropriate, non-acute treatment facility within a reasonable geographic area. (CCR, title 9, § 1820.230(L)(5(B).)

Documentation to review

- P&P
- Beneficiary medical records

9.3.3: The hospital documents contacts with a minimum of five (5) appropriate, non-acute treatment facilities per week subject to the following requirement:

The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities must be documented to include, but not be limited to:

a) The status of the placement option.
b) Date of the contact.
c) Signature of the person making the contact.

(CCR, title 9, § 1820.230(L)(5)(B).)

Documentation to review

- P&P
- Beneficiary medical records

9.4: BENEFICIARY INFORMATION REQUIREMENTS

9.4.1: Oral interpretation, in all languages, and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), shall be made available, free of cost, to beneficiaries. (MHP Contract, Ex. A, Att. 11; 42 C.F.R. § 438.10(d)(2), (4)-(5).)

Documentation to review

- P&P
- Beneficiary medical records

9.4.2: When applicable, there is documentation in the beneficiary's medical record that services were provided, or offered, in the beneficiary's preferred language. (CCR, title 9, § 1810.410)
Document for review

- P&P
- Beneficiary medical records

9.4.3: All written materials for beneficiaries must be made available in alternative formats and through the provision of auxiliary aids and services, in an appropriate manner that takes into consideration the special needs of beneficiaries with disabilities or limited English proficiency. (42 C.F.R. § 438.10(d)(6).)
Documentation for review

- P&P
- Beneficiary medical records

9.4.4: A beneficiary has the right to receive information in accordance with the language and format requirements in 42 C.F.R. § 438.10(d). (42 C.F.R. §438.100(b)(2)(i).)
Documentation to review

- P&P
- Beneficiary medical records

9.4.5: A beneficiary has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand. (42 C.F.R. §438.100(b)(2)(iii).)
Documentation for review

- P&P
- Beneficiary medical records

9.4.6: The MHP documents in the individual's medical record whether or not the beneficiary has executed an advance directive. (42 C.F.R. part 417(K)(iii).)
Documentation to review

- P&P
- Beneficiary medical records

9.5: SCREENING/REFERRAL AND COORDINATION REQUIREMENTS

9.5.1: Services are coordinated between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. (MHP Contract, Ex. A, Att. 10; 42 C.F.R. § 438.208(b)(2).)
Documentation to review

- P&P

- Beneficiary medical records

9.5.2: The record documentation in the beneficiary's chart reflects staff efforts to provide screening, referral, and coordination with other necessary services including, but not limited to, substance abuse, educational, health, housing, vocational rehabilitation and Regional Center services. (CCR, title 9, § 1810.310(a)(2)(A).)
Documentation to review

- P&P
- Beneficiary medical records

9.6: SCOPE OF PRACTICE REQUIREMENTS

9.6.1: Services are delivered by licensed staff within their scope(s) of practice.
Documentation to review

- P&P
- Beneficiary medical records

9.7: WRITTEN PLAN OF CARE REQUIREMENTS

9.7.1: The beneficiary has a written plan of care that includes the following elements: Diagnoses, symptoms, complaints, and complications indicating the need for admission. (42 C.F.R. part 456.180(b)(1).)
Documentation to review

- P&P
- Beneficiary medical record

9.7.2: A description of the functional level of the beneficiary. (42 C.F.R. part 456.180(b)(2).)
Documentation to review

- P&P
- Beneficiary medical records

9.7.3: Specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments resulting from the qualifying mental health diagnosis/diagnoses. (42 C.F.R. § 456.180(b)(3).)
Documentation to review

- P&P
- Beneficiary medical records

9.7.4: Descriptions of the types of interventions/modalities, including a detailed description of the interventions to be provided (which are consistent with the qualifying diagnosis and includes the frequency and duration for each intervention). (42 C.F.R. § 456.180(b)(4).)
Documentation to review

- P&P
- Beneficiary medical records

9.7.5: Any orders for:

a) Medications.
b) Treatments.
c) Restorative and rehabilitative services.
d) Activities.
e) Therapies.
f) Social services.
g) Diet.
h) Special procedures recommended for the health and safety of the beneficiary.(42 C.F.R. § 456.180(b)(4).)

Documentation to review

- P&P
- Beneficiary medical records

9.7.6: Plans for continuing care, including review and modification to the plan of care. (42 C.F.R. § 456.180(b)(5).)
Documentation to review

- P&P
- Beneficiary medical records

9.7.7: Plans for discharge. (42 C.F.R. § 456.180(b)(6).)
Documentation to review

- P&P
- Beneficiary medical records

9.7.8: Documentation of the beneficiary's degree of participation in and agreement with the plan.
Documentation to review

- P&P
- Beneficiary medical records

9.7.9: Documentation of the physician's establishment of the plan. (42 C.F.R. § 456.180(c).)
Documentation to review

- P&P
- Beneficiary medical records

Category 10: Utilization Review- SD/MC Hospital Services

10.1: UTILIZATION REVIEW PLAN

The SD/MC Hospital has a Utilization Review (UR) Plan that: CCR, title 9, § 1820.230; C.F.R. 42 § 456(D)

10.1.1: Provides for a Utilization Review Committee (URC) to perform UR
Documentation to review

- P&P
- UR Plan
- URC Minutes

10.1.2: Describes the organization, composition, and functions of the committee.
Documentation to review

- P&P
- UR Plan
- URC Minutes

10.1.3: Specifies the frequency of the committee meetings.
Documentation to review

- P&P
- UR Plan
- URC Minutes

10.1.4: The UR plan includes the:

a) Identification of the recipient.
b) The name of the recipient's physician.
c) The date of admission.
d) The beneficiary plan of care.
e) Initial and subsequent continued stay review dates.
f) Reasons and plan for continued stay (if the attending physician believes continued stay is necessary).
g) Other supporting material that the committee believes appropriate to be included in the record.

(42 C.F.R. part 456.211-213; 42 C.F.R. part 456.180; 42 C.F.R. parts 456.233 and 456.234)
Documentation to review

- P&P
- UR Plan

The UR plan includes the following review criteria for continued stay in the psychiatric hospital:
10.1.5: Determination of need for continued stay. (42 C.F.R. part 456.231)
Documentation to review

- P&P
- UR Plan

10.1.6: Evaluation criteria for continued stay. (42 C.F.R. part 456.232)
Documentation to review
- P&P
- UR Plan

10.1.7: Initial continued stay review date. (42 C.F.R. part 456.233)
Documentation to review
- P&P
- UR Plan

10.1.8: Subsequent continued stay review dates.(42 C.F.R. part 456.234)
Documentation to review
- P&P
- UR Plan

10.1.9: Description of methods and criteria for continued stay review dates; length of stay modification. (42 C.F.R. part 456.235)
Documentation to review
- P&P
- UR Plan

10.1.10: Continued stay review process. (42 C.F.R. part 456.236)
Documentation to review
- P&P
- UR Plan

10.1.11: Notification of adverse decisions. (42 C.F.R. part 456.237)
Documentation to review
- P&P
- UR Plan

10.1.12: The UR plan describes:
a) The types of records that are kept by the committee; and
b) The type and frequency of committee reports and arrangements for their distribution to appropriate individuals.

(42 C.F.R. part 456.212)
Documentation to review
- P&P
- UR Plan

10.1.13: The UR plan must provide that the identities of individual beneficiaries in all UR records and reports are kept confidential. (42 C.F.R. part 456.213)

Documentation to review
- P&P
- UR Plan

10.2: MEDICAL CARE EVALUATIONS

Regarding Medical Care Evaluations (MCEs) or equivalent studies, the UR plan contains the following:

10.2.1: A description of the methods that the URC uses to select and conduct MCE or equivalent studies. (42 CFR §§ 456.241(a)(b) and 456.242(b)(1).)
Documentation to review
- P&P
- UR Plan
- MCEs or equivalent studies for each year

10.2.2: Documentation of the results of the MCE or equivalent studies that show how the results have been used to make changes to improve the quality of care and promote the more effective and efficient use of facilities and services. (42 CFR § 456.242(b)(2).)
Documentation to review
- P&P
- Current and past MCE or equivalent studies for two years

10.2.3: Documentation that the MCE or equivalent studies have been analyzed. (42 CFR §456.242(b)(3).)
Documentation to review
- P&P
- Current and past MCE or equivalent studies for two years

10.2.4: Documentation that actions have been taken to correct or investigate any deficiencies or problems in the review process and recommends more effective and efficient hospital care procedures. (42 CFR § 456.242(b)(4).)
Documentation to review
- P&P
- Current and past MCE or equivalent studies for two years

10.2.5: The contents of the MCE or equivalent studies meet federal requirements. (42 CFR § 456.243)
Documentation to review
- P&P
- Current and past MCE or equivalent studies for two years

10.2.6: At least one MCE or equivalent study has been completed each calendar year. (42 CFR § 456.245)
Documentation to review
- P&P
- Current and past MCE or equivalent studies for two years

10.2.7: An MCE or equivalent study is in progress at all times. (42 CFR § 456.245)
Documentation to review

- P&P
- Current and past MCE or equivalent studies for two years

10.2.8: The SD/MC hospital has a beneficiary documentation and medical record system that meets the requirements of the contract between the MHP and the department and any applicable requirements of State, federal law and regulation. (MHP Contract)
Documentation to review

- P&P
- Current and past MCE or equivalent studies for two years