MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES
REASONS FOR RECOUPMENT
FISCAL YEAR 2020/2021

NON-HOSPITAL SERVICES

MEDICAL NECESSITY/ASSESSMENT

1. The Mental Health Plan (MHP) did not submit documentation substantiating it complied with the following requirements:
   a) The MHP uses the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) as the clinical tool to make diagnostic determinations. (MHP Contract, Exhibit A, Attachment 3)
   b) Once a DSM-V diagnosis is determined, the MHP shall determine the corresponding mental health diagnosis, in the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) and use the ICD-10 diagnosis code(s) to submit a claim for specialty mental health services (SMHS) to receive reimbursement of Federal Financial Participation in accordance with the covered diagnoses for reimbursement of outpatient and inpatient SMHS.

   MHP Contract, Exhibit A, Attachment 3; Title 9 of the California Code of Regulations § 1830.205(b)(1) and 1830.210; and, Mental Health and Substance Use Disorder Services Information Notices

   Please note: The applicable ICD-10 diagnoses are subject to change. If applicable, changes in covered ICD-10 diagnosis codes will be detailed in MHSUDS Information Notices.

2. Services, except for Crisis Intervention and/or services needed to establish medical necessity criteria, 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. The MHP did not submit documentation substantiating the beneficiary's need for services was established by an Assessment.

   MHP Contract, Exhibit A, Attachment 2

3. The MHP did not submit documentation substantiating that, as a result of an included ICD-10 diagnosis, the beneficiary has, at least, one of the following impairments:
   a) A significant impairment in an important area of life functioning;
   b) A probability of significant deterioration in an important area of life functioning;
   c) A probability the child will not progress developmentally as individually appropriate; or
   d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

   CCR, title 9, chapter 11, section 1830.205(b)(2)(A – C); CCR, title 9, chapter 11, section 1830.210(a)(3)

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CLIENT PLAN

4. Services shall be provided, in accordance with the State Plan, based on the beneficiary's need for services established by an Assessment and documented in the Client Plan. Services were claimed:
   a) Prior to the initial Client Plan being in place; or
   b) During the period where there was a gap or lapse between client plans; or,
   c) When the planned service intervention was not on the current client plan.

   An approved client plan must be in place prior to service delivery for the following SMHS:
   i. *Mental health services (except assessment, client plan development)*
   ii. *Intensive Home Based Services*
   iii. *Specific component of TCM and ICC: Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's individual needs*
   iv. *Therapeutic Behavioral Services*
   v. *Day treatment intensive*
   vi. *Day rehabilitation*
   vii. *Adult residential treatment services*
   viii. *Crisis residential treatment services*
   ix. *Medication Support (non-assessment/evaluation, non-plan development and non-urgent)*
   x. *Psychiatric Health Facility Services (Cal. Code Regs., tit. 22, § 77073.)*
   xi. *Psychiatric Inpatient Services (Code Fed. Regs., tit. 42, § 456.180(a); Cal. Code Regs tit. 9 §§ 1820.230 (b), 1820.220 (l)(i))*

   MHP Contract.; State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025), page 2c; MHSUDS Information Notice 17-040,,

PROGRESS NOTES

5. The MHP did not submit documentation substantiating that the focus of the intervention is to address the beneficiary's included mental health condition.
   a) A significant impairment in an important area of life functioning;
   b) A probability of significant deterioration in an important area of life functioning;
   c) A probability the child will not progress developmentally as individually appropriate; and
   d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

   CCR, title 9, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

6. The MHP did not submit documentation substantiating the expectation that the intervention will do, at least, one of the following:
   a) Significantly diminish the impairment;

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b) Prevent significant deterioration in an important area of life functioning;
c) Allow the child to progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

CCR, title 9, chapter 11, section 1830.205(b)(3)(B); CCR, title 9, chapter 11, section 1810.345(c)

7. The progress note does not describe how services provided to the beneficiary reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.

   MHP Contract, Exhibit A, Attachment 9

8. The MHP did not submit a progress note corresponding to the claim submitted to DHCS for reimbursement, as follows:
   a) No progress note submitted
   b) The progress note provided by the MHP does not match the claim submitted to DHCS for reimbursement in terms of the following:
      i. Specialty Mental Health Service claimed.
      ii. Date of service, and/or
      iii. Units of time.

   CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), CCR, title 22, section 51458.1(a)(3)(4); MHP Contract ; CCR, title 9, section 1840.112(b)(3)

9. The service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation (e.g., Institution for Mental Disease [IMD], jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11).

   NOTE: When a beneficiary who resides in a setting in which s/he would normally be ineligible for Medi-Cal is moved off grounds to an acute psychiatric inpatient hospital or PHF, that individual again becomes Medi-Cal eligible (unless the hospital is free-standing with more than 16 beds and is thus considered an IMD and the beneficiary is between the ages of 21-64).

   CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, part 435, *sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d*

10. The service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (A dependent minor in a juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary, is Medi-Cal eligible. See CCR, title 22, section 50273(c)(5) A

delinquent minor is only Medi-Cal eligible after adjudication for release into community. See CCR, title 22, section 50273(c)(1))

Code of Federal Regulations, title 42, sections 435.1009 – 435.1010; CCR, title 22, section 50273(a)(5-8), (c)(1, 5)

11. The service provided was solely for one of the following:
    a) Academic educational service
    b) Vocational service that has work or work training as its actual purpose
    c) Recreation
    d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors
    e) Transportation
    f) Clerical
    g) Payee Related

    CCR, title 9, sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); title 22, chapter 3, section 51458.1(a)(5),(7);

12. The claim for a group activity, which is provided as a Mental Health Service, Medication Support, Crisis Intervention, or TCM service, was not properly apportioned to all clients present, and resulted in excess time claimed.

    CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; MHSUDS Information Notice 17-040

13. For service activities involving one (1) or more providers, progress notes, or other relevant documentation in the medical record, did not clearly include the following:
    a) The total number of providers and their specific involvement r in the context of the mental health needs of the beneficiary; or
    b) The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable; *or*
    c) The total number of beneficiaries participating in the service activity.

    CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; MHSUDS Information Notice 17-040

14. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

    MHP Contract; MHSUDS Information Notice 17-040

15. The MHP did not submit documentation that a valid services was provided to, or on behalf of, the beneficiary:

a) No show / appointment cancelled, and no other eligible service documented (e.g., chart review to prepare for an appointment that turns out to be a "no show'), or
b) Service provided did not meet the applicable definition of a SMHS.

CCR, title 9, section 1840.112(b)(3); title 22, section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1

16. The service provided was not within the scope of practice of the person delivering the service.

CCR, title 9, section 1840.314(d); MHSUDS Information Notice 17-040

DAY TREATMENT INTENSIVE / DAY REHABILITATION (DTI / DR)

17. On a day where the beneficiary was present for at least 50% of the scheduled DTI/DR program time, but was not in attendance for the full hours of operation for that day, there is no documentation of the reason for an "unavoidable absence" which clearly explains why the beneficiary could not be present for the full program on the day claimed.

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;

18. The actual number of hours and minutes the beneficiary attended the DTI/DR program (e.g., 3 hours and 58 minutes) is not documented and for this reason it cannot be established that the beneficiary was present for at least 50% of the program time for the day reviewed.

DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;

19. Documentation reviewed, including the written weekly schedule for DTI/DR along with the progress notes, reflects that the program does not meet the time requirements for a half-day or full-day program as follows:
    a) Breaks and/or meal times were counted in order to meet the time requirements,
    b) Half day program was less than 3 hours (requirement is for 4 hours or less, but a minimum of 3 hours)
    c) Full day program was 4 hours or less (requirements is for more than 4 hours)

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

20. Required DTI/DR documentation was not present as follows:
    a) There was not a clinical summary present for Day Treatment Intensive Services for the week of the service reviewed
    b) There was not a daily progress note present for Day Treatment Intensive Services for the day of the service reviewed
    c) There was not a weekly progress note present for Day Rehabilitation Services for the week of the service reviewed

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CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

HOSPITAL SERVICES

MEDICAL NECESSITY

21. Admission
   a) Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).
   b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.
   c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:
      i. Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
      ii. Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
      iii. Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
      iv. Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
      v. Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized

CCR, title 9, section 1820.205(a); See Also title 9, sections 1820.220, 1820.225 and 1820.230.

22. Continued Stay Services
   a) Documentation in the medical record does not establish the continued presence of a diagnosis contained in Section 1820.205(a)(1)(A-R)
   b) Documentation in the medical record does not establish that the beneficiary could not 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 shall be considered to have met this criterion
   c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires continued stay services in an acute psychiatric inpatient hospital for one of the following reasons:
      i. Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
      ii. Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter

iii. Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
iv. Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
v. Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized
vi. Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
vii. Presence of new indications that meet medical necessity criteria specified in 22.a.above
viii. Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital

*CCR, title 9, section 1820.*205 See *Also title 9, sections 1820.220, 1820.225 and 1820.230.*

ADMINISTRATIVE DAY REQUIREMENTS

23. Documentation in the medical record does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

    CCR, title 9, section 1820.205(b,) See Also sections 1820.220(a)(5), (l)(5)(A), 1820.230(a)(2), (d)(1),(2)(A).

24. Documentation provided by the MHP does not establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital does not document contacts with a minimum of five (5) appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements:
    a) The MHP or its designee may waive the requirement of five (5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one (1) contact per week.
    b) The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:
        i. The status of the placement option
        ii. The date of the contact
        iii. Signature of the person making the contact

    CCR, title 9, sections 1820.220(a)(5), (l)(5)(B), 1820.230(d)(2)(B)

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CLIENT PLAN

25. The medical record does not contain a written plan of care (also referred to as a client plan) for a beneficiary.

    Code of Federal Regulations, title 42, section 456.180; CCR, title 9, section 1820.210

26. The physician did not establish a written plan of care (or client plan) prior to the authorization of payment, which must be done either by the MHPs Point of Authorization prior to admission of the beneficiary or by the hospital Utilization Review Committee or its designee, “no later than the third working day from the day of [the beneficiary’s] admission.”

    NOTE: The physician’s signature and date on the written plan of care indicates their establishment of the plan.

    Code of Federal Regulations, title 42, section 456.180(a): CCR, title 9, sections 1820.210, 1820.220(a)(1) and 1820.230(a)(1), (2) and (b)

OTHER

27. A hospital day was claimed and paid (1) on which the beneficiary was not a patient in the hospital or (2) for the day of discharge, neither of which is reimbursable.

    CCR, title 9, section 1840.320(b)(1), (3); Title 22, section 51470(a) 840.320(b)(1)(3)