FISCAL YEAR (FY) 2016/2017 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
SONOMA COUNTY MENTAL HEALTH PLAN REVIEW
April 17, 2017 – April 20, 2017
FINDINGS REPORT

AMENDED

Section K, "Chart Review – Non-Hospital Services

The medical records of ten (10) adult and ten (10) child/adolescent Medi-Cal specialty mental health beneficiaries were reviewed for compliance with state and federal regulations; adherence to the terms of the contract between the Sonoma County Mental Health Plan (MHP) and the California Department of Health Care Services (DHCS), and for consistency with the MHP's own documentation standards and policies and procedures regarding medical records documentation. The process included a review of **689** claims submitted for the months of July, August, and September of 2015.

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Medical Necessity

	PROTOCOL REQUIREMENTS
1. 1a.	Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c. below)? The beneficiary has a current ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract?
1b.	The beneficiary, as a result of a mental disorder or emotional disturbance listed in 1a, must have at least one (1) of the following criteria (1-4 below): 1) A significant impairment in an important area of life 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.
	Do the proposed and actual intervention(s) meet the intervention criteria listed below: 1) The focus of the proposed and actual intervention(s) is to address 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 SMHS can correct or ameliorate per No. 1b(4).
	2) 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.
1d.	The condition would not be responsive to physical health care based treatment.

- *CCR, title 9, chapter 11, section 1830.205 (b)(c)*
- *CCR, title 9, chapter 11, section1830.210*
- *CCR, title 9, chapter 11, section 1810.345(c)*
- *CCR, title 9, chapter 11, section 1840.112(b)(1-4)*
- *CCR, title 9, chapter 11, section 1840.314(d)*
- *CCR, title 22, chapter 3, section 51303(a)*
- *Credentialing Boards for MH Disciplines*

Reasons for Recoupment (RR): ***Refer to the enclosed Recoupment Summary for additional details concerning disallowances***

RR1. Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

RR2. Documentation in the medical record does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the identified functional impairments.

RR3. Documentation in the medical record does not establish that the focus of the proposed intervention is to address the functional impairment identified in CCR, title 9, chapter 11, section 1830.205(b)(2)

RR4. Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:
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; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

FINDING 1c-1:
The medical record associated with the following Line numbers did not meet the medical necessity criteria since the focus of the proposed interventions did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A):

- **Line numbers [1]. RR3, refer to Recoupment Summary for details**

PLAN OF CORRECTION 1c-1:
The MHP shall submit a POC that describes how the MHP will ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition as specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

Assessment *(Findings in this area do not result in disallowances. Plan of Correction only.)*

PROTOCOL REQUIREMENTS	
	Regarding the Assessment, are the following conditions met: 1) Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness?
	2) Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency?
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 2a:
Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

One or more assessments were not completed within the update frequency requirements specified in the MHP's written documentation standards. The following are specific findings from the chart sample:

- **Line number [2]**: There was no updated assessment found in the medical record.
  During the review, MHP staff were given the opportunity to locate the missing assessment but could not locate the document in the medical record.
- **Line number [3]**: The updated assessment was completed seven (7) days late.
- **Line number [4]**: The updated assessment was completed 27 days late.
- **Line number [5]**: The updated assessment was completed 17 days late.
- **Line number [6]**: The updated assessment was completed four (4) days late.

PLAN OF CORRECTION 2a:

[1] Line number(s) removed for confidentiality
[2] Line number(s) removed for confidentiality
[3] Line number(s) removed for confidentiality
[4] Line number(s) removed for confidentiality
[5] Line number(s) removed for confidentiality
[6] Line number(s) removed for confidentiality

The MHP shall submit a POC that describes how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

PROTOCOL REQUIREMENTS	
	Do the Assessments include the areas specified in the MHP Contract with the Department? 1) Presenting Problem. The beneficiary's chief complaint, history of 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 and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;
	3) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports;
	4) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports
	5) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications;
	6) 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;
	7) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
	8) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
	9) A mental status examination;
	10) A Complete Diagnosis; A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 2b:

One or more of the assessments reviewed did not include all of the elements specified in the MHP Contract with the Department. The following required elements were incomplete or missing**:**

1) Presenting Problem(s): **Line number [7].**

[7] Line number(s) removed for confidentiality

2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health: **Line number [8].**
3) Mental Health History: **Line numbers [9].**
4) Medical History: **Line numbers [10].**
5) Medications: **Line numbers [11].**
6) Substance Exposure/Substance Use: **Line numbers [12].**
7) Client Strengths: **Line number [13].**
8) Risks: **Line number [14].**
9) Mental status examination: **Line numbers [15].**
10) Full DSM diagnosis or current ICD code: **Line number [16].**

PLAN OF CORRECTION 2b:
The MHP shall submit a POC that describes how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department.

Medication Consent *(Findings in this area do not result in disallowances. Plan of Correction only.)*

PROTOCOL REQUIREMENTS	
	Does the medication consent for psychiatric medications include 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?
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

[8] Line number(s) removed for confidentiality
[9] Line number(s) removed for confidentiality
[10] Line number(s) removed for confidentiality
[11] Line number(s) removed for confidentiality
[12] Line number(s) removed for confidentiality
[13] Line number(s) removed for confidentiality
[14] Line number(s) removed for confidentiality
[15] Line number(s) removed for confidentiality
[16] Line number(s) removed for confidentiality

FINDING 3b:
Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented to have been reviewed with the beneficiary:

1) Method of administration (e.g., oral or injection): **Line numbers [17].**
10) Consent once given may be withdrawn at any time: **Line numbers [18].**

PLAN OF CORRECTION 3b - Note:
The MHP provided evidence for the addition, on its current medication consent form, of documentation that "method of administration" and "right of withdrawal at any time" is reviewed with the beneficiary. Therefore, no Plan of Correction is required at this time for Finding 3b.

Client Plans

PROTOCOL REQUIREMENTS		
4a	1) Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?	
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*		• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

Reasons for Recoupment (RR): ***Refer to the enclosed Recoupment Summary for additional details concerning disallowances***

RR6. The client plan was not completed, at least, on an annual basis or as specified in the MHP's documentation guidelines.

FINDING 4a-2:
The client plan was not updated at least annually, or when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department), or updated at another frequency specified in the MHP's documentation standards**:**

- **Line number [19]**: There was **no** updated client plan in the medical record. During the review, MHP staff was given the opportunity to locate the document in question but could not find written evidence of it in the medical record. **RR6, refer to Recoupment Summary for details**

  The MHP should review all services and the claims identified during the audit for which there was no client plan in effect and disallow those claims as required.

[17] Line number(s) removed for confidentiality
[18] Line number(s) removed for confidentiality
[19] Line number(s) removed for confidentiality

- **Line numbers [20]:** There was a **lapse** between the prior and current client plans. However, this occurred outside of the audit review period.

  The MHP should review all services and claims identified during the audit that were claimed outside of the audit review period for which there was no client plan in effect and disallow those claims as required.

- **Line numbers [21]**: There was a **lapse** between the prior and current client plans. However, no services were claimed.

- **Line number [22]**: There was **no** updated client plan for one type of service being claimed. During the review, MHP staff was given the opportunity to locate the service in question on a client plan that was effective on the date of service but could not find written evidence of it. **RR6, refer to Recoupment Summary for details**

  The MHP should review all services and claims identified during the audit for which there was no client plan for the services in question and disallow those claims as required.

PLAN OF CORRECTION 4a-2:

The MHP shall submit a POC that describes how the MHP will:

1) Ensure that client plans are completed at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and update frequency specified in the MHP's written documentation standards.
2) Ensure that all types of interventions/service modalities provided and claimed are recorded as proposed interventions on a current client plan.
3) Ensure that non-emergency services are not claimed when:
   a) A client plan has not been completed.
   b) The service provided is not included in the current client plan.
4) Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.

PROTOCOL REQUIREMENTS	
	Does the client plan include the items specified in the MHP Contract with the Department? 1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.
	2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.
	3) The proposed frequency of intervention(s).
	4) The proposed duration of intervention(s).
	5) Interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.
	6) Interventions are consistent with client plan goal(s)/treatment objective(s).

[20] Line number(s) removed for confidentiality
[21] Line number(s) removed for confidentiality
[22] Line number(s) removed for confidentiality

	7) Be consistent with the qualifying diagnoses.
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*	• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

FINDING 4b:
The following Line numbers had client plans that did not include all of the items specified in the MHP Contract with the Department:

4b-1) One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis. **Line numbers [23].**

4b-2) One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan (e.g. "Medication Support Services," "Targeted Case Management," "Mental Health Services," etc.). **Line numbers [24].**

4b-3) One or more of the proposed interventions did not indicate an expected frequency. **Line numbers [25].**

4b-4) One or more of the proposed interventions did not indicate an expected duration. **Line number [26].**

PLAN OF CORRECTION 4b:
The MHP shall submit a POC that describes how the MHP will ensure that:

1) All client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.
2) All mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).
3) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

Progress Notes

PROTOCOL REQUIREMENTS

[23] Line number(s) removed for confidentiality
[24] Line number(s) removed for confidentiality
[25] Line number(s) removed for confidentiality
[26] Line number(s) removed for confidentiality

5a.	Do the progress notes document the following:
	1) Timely documentation (as determined by the MHP) 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?
	2) Documentation of referrals to community resources and other agencies, when appropriate?
	3) Documentation of follow-up care or, as appropriate, a discharge summary?
	4) The amount of time taken to provide services?
	5) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?

• *CCR, title 9, chapter 11, section 1810.254*	• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322*
• *CCR, title 9, chapter 11, section 1810.440(c)*	• *CCR, title 22, chapter 3, section 51458.1*
• *CCR, title 9, chapter 11, section 1840.112(b)(2-6)*	• *CCR, title 22, chapter 3, section 51470*
• *CCR, title 9, chapter 11, section 1840.314*	• *MHP Contract, Exhibit A, Attachment I*

Reasons for Recoupment (RR): *Refer to the enclosed Recoupment Summary for additional details concerning disallowances*

RR1. Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

RR2. Documentation in the medical record does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the identified functional impairments.

RR3. Documentation in the medical record does not establish that the focus of the proposed intervention is to address the functional impairment identified in CCR, title 9, chapter 11, section 1830.205(b)(2)

RR4. Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:
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; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

RR9. No progress note was found for service claimed.

RR10. The time claimed was greater than the time documented.

RR13 The progress note indicates that 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; or
d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.

RR15. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

RR16. The progress note indicates the service provided was solely transportation.

RR17. The progress note indicates the service provided was solely clerical.

RR18. The progress note indicates the service provided was solely payee related.

RR19a. No service was provided.

RR19b.The service was claimed for a provider on the Office of Inspector General List of Excluded Individuals and Entities.

RR19c.The service was claimed for a provider on the Medi-Cal suspended and ineligible provider list

RR19d. The service was not provided within the scope of practice of the person delivering the service.

FINDING 5a:

Progress notes were not completed in accordance with regulatory and contractual requirements and/or with the MHP's own written documentation standards**:**

- One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements.
- The MHP was not following its own written documentation standards for timeliness of staff signatures on progress notes.
- Progress notes did not document the following:

5a-1) **Line numbers** [27]: Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period).

5a-4) **Line numbers** [28]: Timeliness of the progress note could not be determined because the note was signed but not dated by the person providing the service. Therefore, the date the progress note was entered into the medical record could not be determined.

5a-8) **Line numbers** [29]: The provider's professional degree, licensure or job title.

- Appointment was missed or cancelled: **Line number** [30]. **RR19a, refer to Recoupment Summary for details.**

PLAN OF CORRECTION:

The MHP shall submit a POC that describes how the MHP will:

1) Ensure that progress notes meet timeliness, frequency and the staff signature requirements in accordance with regulatory and contractual requirements.
2) Ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.
3) The MHP shall submit a POC that describes how the MHP will ensure that progress notes document**:**

   5a-1) Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and the MHP's written documentation standards.

[27] Line number(s) removed for confidentiality
[28] Line number(s) removed for confidentiality
[29] Line number(s) removed for confidentiality
[30] Line number(s) removed for confidentiality

5a-4) The date the progress note was completed and entered into the medical record by the person(s) providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.

5a-8) The provider's professional degree, licensure or job title.

FINDING 5a3:

The progress notes for the following Line numbers indicate that the service provided was Solely Clerical and therefore did not meet medical necessity: **Line numbers [31].**
RR17, refer to Recoupment Summary for details.

PLAN OF CORRECTION:

The MHP shall submit a POC that describes how the MHP will ensure that:

1) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning, as outlined in the client plan.
2) Services provided and claimed are not solely transportation, clerical or payee related.
3) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).

PROTOCOL REQUIREMENTS	
	When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes 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, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*	• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

FINDING 5b:

Documentation of services being provided to, or on behalf of, a beneficiary by two or more persons at one point in time did not include all required components. Specifically:

- **Line number [32]**: Six (6) progress notes did not document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary.

[31] Line number(s) removed for confidentiality
[32] Line number(s) removed for confidentiality

PLAN OF CORRECTION 5b:
The MHP shall submit a POC that describes how the MHP will ensure that:

1) Group progress notes clearly document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary.
2) There is medical necessity for the use of multiple staff in the group setting.

PROTOCOL REQUIREMENTS	
5c.	Timeliness/frequency as follows: 1) Every service contact for: A. Mental health services B. Medication support services C. Crisis intervention D. Targeted Case Management 2) Daily for: A. Crisis residential B. Crisis stabilization (one per 23/hour period) C. Day treatment intensive 3) Weekly for: A. Day treatment intensive (clinical summary) B. Day rehabilitation C. Adult residential
• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*	• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

FINDING 5c:
Documentation in the medical record did not meeting the following requirements:

- **Line number** [33]: There were no progress notes in the medical record for 11 service claims. **RR9, refer to Recoupment Summary for details.**

  During the review, the MHP staff was given the opportunity to locate the documents in question but could not find written evidence of them in the medical record.

- **Line numbers** [34]: The type of specialty mental health service (SMHS) documented on the progress note was not the same type of SMHS claimed. **RR9, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5c:
The MHP shall submit a POC that describes how the MHP will ensure that all SMHS claimed are:

a) Documented in the medical record.

[33] Line number(s) removed for confidentiality
[34] Line number(s) removed for confidentiality

b) Actually provided to the beneficiary.

c) Claimed for the correct service modality and billing code.

d) Accurate and meet the documentation requirements described in the MHP Contract with the Department.

PROTOCOL REQUIREMENTS	
	Do all entries in the beneficiary's medical record include: 1) The date of service?
	2) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?
	3) The date the documentation was entered in the medical record?
• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*	• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

FINDING 5d:

The Progress notes did not include:

- The signature of the person providing the service (or electronic equivalent) as specified in the MHP Contract with the Department: **Line numbers** [35]. **RR15, refer to Recoupment Summary for details.**
- The provider's professional degree, licensure, or job title: **Line numbers** [36]**.**
- Date the documentation was entered into the medical record: **Line numbers** [37]**.**
- The following Line number had a progress note indicating that the documented and claimed service provided was not within the scope of practice of the person delivering the service**:**
  a. A non-medical, Mental Health Rehabilitation Specialist / Case Manager provided medication consultation advice to the beneficiary although the provider was not qualified to deliver and claim for this type of service: **Line number** [38]**. RR19d, refer to Recoupment Summary for additional details.**

  The MHP should review all services and claims provided by the staff who was not qualified and disallow claims as required.

PLAN OF CORRECTION 5d:

The MHP shall submit a POC that describes how the MHP will**:**

1) Ensure that all documentation includes the signature or (electronic equivalent) with the professional degree, licensure or title of the person providing the service.

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[35] Line number(s) removed for confidentiality
[36] Line number(s) removed for confidentiality
[37] Line number(s) removed for confidentiality
[38] Line number(s) removed for confidentiality

2) Ensure that all documentation includes the date the signature was completed and the document was entered into the medical record.
3) Ensure all services claimed are provided by the appropriate and qualified staff within his or her scope of practice, if professional licensure is required for the service.
4) Ensure that staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.
5) Ensure that services are not claimed when services are provided by staff outside the staff's scope of practice or qualifications.
6) Provide evidence that all claims in which the staff was not qualified to provide services were disallowed.