FISCAL YEAR (FY) 2016/2017 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
STANISLAUS COUNTY MENTAL HEALTH PLAN REVIEW
January 30 – February 2, 2017
DRAFT FINDINGS REPORT

Amended

Section K, "Chart Review – Non-Hospital Services

The medical records of seven (7) 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 Stanislaus 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 **362** claims submitted for the months of October, November, and December of 2015.

Contents

Medical Necessity

PROTOCOL REQUIREMENTS	
1.	Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c. below)?
1a.	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 number did not meet the medical necessity criteria since the focus of the proposed intervention did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A):

- **Line number [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).

FINDING 1c-2:
The medical record associated with the following Line numbers did not meet the medical necessity criteria since there was no expectation that the documented interventions would meet the intervention criteria as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4):

- **Line numbers [2]. RR4, refer to Recoupment Summary for details**

PLAN OF CORRECTION 1c-2:
The MHP shall submit a POC that describes how the MHP will ensure that the interventions provided meet the intervention criteria specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4).

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*

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

[1] Line number(s) removed for confidentiality
[2] Line number(s) removed for confidentiality

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

- **Line number [3]**: An updated assessment was completed (323) days late.
- **Line number [4]**: An updated assessment was completed (14) days late
- **Line number [5]**: An updated assessment was completed (99) days late

PLAN OF CORRECTION 2a:

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.

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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;

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

	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) Medical History: **Line number [6].**
2) Medications: **Line numbers [7].**
3) A mental status examination: **Line number [8].**

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.

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:

[6] Line number(s) removed for confidentiality
[7] Line number(s) removed for confidentiality
[8] Line number(s) removed for confidentiality

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 and/or as specified in the MHP's documentation standards):

- **Line numbers [9]**: 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.

PLAN OF CORRECTION 4a-2:

The MHP shall submit a POC that indicates 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 frequency specified in the MHP's written documentation standards.
2) 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.
3) 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.
4) Ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

Progress Notes

PROTOCOL REQUIREMENTS	
	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?

[9] Line number(s) removed for confidentiality

• *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*

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**:**

- 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 number [10]**: 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).

- Appointment was missed or cancelled: **Line number [11]**. **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.

   That the documentation is individualized for each service provided.

   That each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning.

FINDING 5a3:

The following Line number had documentation indicating a Specialty Mental Health Service (SMHS) was provided while the beneficiary resided in a setting that was ineligible for Federal Financial Participation or resided in a setting subject to lockout:

- Service was provided and claimed while the beneficiary resided in an Institution for Mental Disease. **Line number [12]**. **RR11, refer to Recoupment Summary for details.**

PLAN OF CORRECTION:

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

1) Services claimed were provided in a setting where the beneficiary was eligible for FFP and not subject to lockout.

[10] Line number(s) removed for confidentiality
[11] Line number(s) removed for confidentiality
[12] Line number(s) removed for confidentiality

2) Progress notes clearly and accurately document the beneficiary's response and the specific interventions applied, as specified in the MHP Contract with the Department.
3) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning.
4) 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 [13]**: One progress note 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.

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

[13] Line number(s) removed for confidentiality

	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 [14]**: There was no progress note in the medical record for two (2) of the services claimed. **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.

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

1) Ensure that all SMHS claimed are:
   a) Documented in the medical record.
   b) Actually provided to the beneficiary.
   c) Claimed for the correct service modality and billing code.
   d) Claimed to provider who actually provided the services.
2) Ensure that all progress notes are accurate and meet the documentation requirements described in the MHP Contract with the Department.

Service Components for Day Treatment Intensive and Day Rehabilitation Programs

PROTOCOL REQUIREMENTS

[14] Line number(s) removed for confidentiality

7e.	Regarding Documentation Standards: 1) Is the required documentation timeliness/frequency for *Day Treatment Intensive* or *Day Rehabilitation* being met? A. For *Day Treatment Intensive* services: • Daily progress notes on activities; and • A weekly clinical summary B. For *Day Rehabilitation* services: • Weekly progress note	
	2) Do 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; and F. The total number of minutes/hours the beneficiary actually attended the program?	
• *CCR, title 9, chapter 11, section 1810.212* • *CCR, title 9, chapter 11, section 1810.213* • *CCR, title 9, chapter 11, section 1840.112(b)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*		• *CCR, title 9, chapter 11, section 1840.318* • *CCR, title 9, chapter 11, section 1840.360* • *MHP Contract, Exhibit A, Attachment I* • *DMH Letter No. 03-03*

FINDING 7e:

Documentation for the following Line numbers indicated that an essential requirement for a Day Rehabilitation program was not met on a consistent basis, as specified by the MHP Contract with the Department:

- **Line numbers** [15]: Entries in the medical record did not consistently document - during each month Day Program services were claimed - the provision of at least one (1) monthly contact with the beneficiary's family member, caregiver or other significant support person identified by an adult beneficiary, or at least one (1) contact per month with the legally responsible adult for a beneficiary who is a minor, and that these contacts occurred outside of the Day Program's normal hours of operation.

PLAN OF CORRECTION 7e:

The MHP shall submit a POC that describes how the MHP will ensure that its Day Program providers consistently document the occurrence, outside of Day Program hours of operation, of at least one (1) monthly contact with a family member, caregiver, significant other or legally responsible adult.

[15] Line number(s) removed for confidentiality