DEPARTMENT OF HEALTH CARE SERVICES
REVIEW OF GLENN MENTAL HEALTH PLAN
MARCH 6-7, 2019
CHART REVIEW FINDINGS REPORT

Chart Review – Non-Hospital Services

The medical records of five (5) adult and five (5) 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 **176** claims submitted for the months of **January, February, and March of 2018**.

Contents

Assessments

REQUIREMENTS
The MHP shall ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed: a) 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; b) 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; c) 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; d) 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; e) 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 shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications; f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs; g) 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; h) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma; i) A mental status examination; j) A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and, k) Additional clarifying formulation information, as needed. (MHP Contract, Ex. A, Att. 9)

FINDINGS

One or more of the Assessments submitted to DHCS did not address all of the elements as required in the MHP Contract. Below are the specific findings pertaining to the chart review sample:

- **Line number [1]:** Assessment (annual) completed on [2] did not address medications. The Assessment did not include an update regarding the beneficiary's current medications, nor did the assessment indicate "no change" or refer to prior documentation in the medical record.
- **Line number [3].** Assessment (annual) completed on [4] did not address substance exposure/substance use. The Assessment did not include an update about the beneficiary's current substance exposure/substance use status.
- **Line numbers [5]:** Assessments did not include a complete diagnosis from the current ICD code. The MHP's practice is to require completion of separate assessment and diagnosis forms. In the noted line numbers, if a diagnosis form was not completed at the time of Assessment, the MHP practice, per its policy, is to document in the beneficiary's Assessment the link to a prior diagnoses. The MHP's assessment forms include a signed attestation statement, "By signing this assessment, I acknowledge that I have reviewed the most recent diagnosis review form and, if needed, I have completed an updated diagnosis review form." For these line numbers, the completed assessment forms indicated that updates to the diagnosis form were needed; however, the MHP was unable to locate, and did not submit, the corresponding diagnosis forms.

PLAN OF CORRECTION

- 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.
- The MHP shall submit a POC that describes how the MHP will ensure that a full diagnosis from the current ICD code is included with all assessments.

Medication Consents

REQUIREMENTS
The provider must obtain and retain 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)

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[2] Date(s) removed for confidentiality
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[4] Date(s) removed for confidentiality
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FINDINGS

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. The MHP did not submit documentation that the medical recorded contained a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent. Below are the specific findings pertaining to the chart review:

- **Line number [6]**: The MHP did not submit a completed written medication consent form for each of the medications prescribed to the beneficiary. Medication consent form(s) did not address consent for the following: Abilify, Prazosin, Hydroxyzine, and Buspirone.

  Please note: During the pre-review and on-site, the MHP was given the opportunity to locate the medication consents in question but were unable to locate them in the medical record.

- **Line number [7]**: Written medication consent form(s) signed by the beneficiary included consent for medications no longer prescribed to the beneficiary. Specifically, medication consent forms included the prescription drug Focalin, but progress notes from the associated time period indicated that the beneficiary was no longer being prescribed Focalin.

PLAN OF CORRECTION

The MHP shall submit a POC to address actions it will implement to ensure the following:

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.
2) Written medication consent forms are completed in accordance with the MHP's written documentation standards.

REQUIREMENTS

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Medication consent for psychiatric medications shall 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.

(MHP Contract, Ex. A, Attachment 9)

FINDING

Medication consents did not address all elements required in the MHP Contract. In addition, the MHP did not submit evidence that these required elements were discussed with the beneficiary or that the MHP provided the beneficiary with required written information about the medications which address the requirement. Below are the specific findings pertaining to the chart review:

- **Line numbers [8]:** Possible side effects if taken longer than 3 months. A review of the medication consent forms utilized by the MHP revealed that there was insufficient information being provided to beneficiaries regarding possible side-effects of medications if taken longer than 3 months. Further, there was no additional information provided by the MHP to corroborate that additional side-effect information was provided to the beneficiary either in oral or written form.

PLAN OF CORRECTION

The MHP shall submit a POC that describes how the MHP will ensure that every medication consent process addresses all of the required elements specified in the MHP Contract with the Department.

Client Plans

REQUIREMENTS

[8] Line number(s) removed for confidentiality

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. (MHP Contract; State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025), page 2c; MHSUDS Information Notice 17-040)
The client plan shall be updated at least annually, or when there are significant changes in the beneficiary's condition. (MHP Contract, Ex. A, Attachment 9)

FINDING

Client Plans were not completed prior to the delivery of planned services and/or were not updated at least annually or reviewed and updated 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). Below are the specific findings pertaining to the chart review sample:

- **Line number [9]:** There was a lapse between the prior and current client plans and, therefore, there was no client plan in effect during a portion or all of the audit review period. Per its policy, the MHP requires a client plan to be updated annually or as needed. Based on completion/signature date of [10], the Client Plan expired on [11] and interventions performed after this date were done when no client plan was in effect. Refer to Recoupment Summary for additional details.

Please note: During the onsite review, the MHP was given an opportunity to locate a Client Plan applicable during the time-period.

PLAN OF CORRECTION

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

1) Ensure that client plans are updated 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 client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.
3) Ensure that client plans address all elements relevant to the beneficiary's condition or diagnosis.

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[11] Date(s) removed for confidentiality

REQUIREMENTS
The MHP shall ensure that Client Plans: a) Have 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. b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided. c) Have a proposed frequency of intervention(s). d) Have a proposed duration of intervention(s). e) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b). f) Have interventions that are consistent with the client plan goals. g) Be consistent with the qualifying diagnoses. (MHP Contract, Ex. A, Attachment 9)

FINDINGS

Client Plans did not include all of the required elements specified in the MHP Contract. Below are the specific findings pertaining to the chart review sample:

- **Line numbers [12]:** 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 [13]:** One or more of the proposed interventions did not include a detailed description. Instead, only a generic description of the intervention was recorded on the client plan.
- **Line numbers [14]:** One or more of the proposed interventions did not indicate an expected duration.
- **Line numbers [15]:** One or more client plans did not address the mental health needs and functional impairments identified as a result of the mental disorder.
    - **Line [16]**: The beneficiary was diagnosed with Major Depressive Disorder and Posttraumatic Stress Disorder (PTSD), but the client plan only notes interventions addressing depression and anxiety, not PTSD specifically.
    - **Line [17]**: The beneficiary was diagnosed with PTSD and Major Depressive Disorder, but the client plan appears primarily focused on addressing depression symptoms, without a specific focus on addressing PTSD symptoms.

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PLAN OF CORRECTION

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.
4) All mental health interventions/modalities proposed on client plans address the mental health needs and identified functional impairments of the beneficiary as a result of the mental disorder.

Progress Notes

REQUIREMENTS
The MHP shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include: a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity; b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions; c) Interventions applied, beneficiary's response to the interventions and the location of the interventions; d) The date the services were provided; e) Documentation of referrals to community resources and other agencies, when appropriate; f) Documentation of follow-up care, or as appropriate, a discharge summary; and g) The amount of time taken to provide services; and h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title. (MHP Contract, Ex. A, Attachment 9)

FINDING

Progress notes did not include timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity, as required in the MHP Contract. One or more progress notes was not completed within the timeliness and/or frequency standards in accordance with the MHP Contract and the MHP's written documentation standards. Below are the specific findings pertaining to the chart review sample:

- **Line numbers [18]:** Progress notes associated with the following line number(s) did not include 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).

  MHP's policy statement (Glenn County Health and Human Services Agency, BH 1011, Progress Notes and Late Entry Documentation) indicates for documentation to be completed "…by the end of the next business day. With supervisor approval, progress notes may be completed up to a maximum of three (3) business days from the date of service."

  - **Line [19]:** One note signed [20] for service claimed on [21], exceeded the 3 business day discretionary period.
  - **Line [22]:** One note signed [23] for service claimed on [24], exceeded the 3 business day discretionary period.
  - **Line [25]:** Two notes signed [26] for services claimed on [27], exceeded the 3 business day discretionary period.
- **Line number [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, and the note was considered to be late.

  The MHP submitted a contracted TBS provider's notes in which provider signs, but does not separately date progress notes. This practice does not adequately confirm the date the progress note was completed and entered into the medical record.

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- **Line numbers [29]:** The provider's professional degree, licensure or job title was missing from progress notes.

Please note: The MHP informed reviewers that the Electronic Health Record (EHR) had a technical problem during a period of time in which the professional degree, licensure, or job title was not embedded with some electronic signatures. However, the MHP was able to confirm that the associated providers had active licenses or degrees during the noted time-periods.

PLAN OF CORRECTION

1) The MHP shall submit a POC that describes how the MHP will ensure that progress notes document**:**
   - Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.
   - 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.
   - The provider's/providers' professional degree, licensure or job title.

REQUIREMENTS
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 must 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).)

FINDING

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. Below are the specific findings pertaining to the chart review sample:

- **Line number [30]**: Progress note(s) did not accurately document the number of group participants. The progress notes for groups held on [31] and [32] did not display the correct number of group participants. The MHP indicated that there are limitations on what their EHR can display regarding the number of participants on their group notes.

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PLAN OF CORRECTION

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

1) All group progress notes document the number of clients in the group, number of staff, units of time, type of service and dates of service (DOS).
2) The number of clients in the group, number of staff, units of time, type of service and dates of service (DOS) documented on the group progress notes are accurate and consistent with the documentation in the medical record and that services are not claimed when billing criteria are not met.
3) Group progress notes clearly document the beneficiary's response, the beneficiary encounters, and interventions applied, as specified in the MHP Contract with the Department.

REQUIREMENTS
Progress notes shall be documented at the frequency by type of service indicated below: a) Every Service Contact: i. Mental Health Services; ii. Medication Support Services; iii. Crisis Intervention; iv. Targeted Case Management; b) Daily: i. Crisis Residential; ii. Crisis Stabilization (1x/23hr); iii. Day Treatment Intensive; c) Weekly: i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service; ii. Day Rehabilitation; iii. Adult Residential. (MHP Contract, Ex. A, Attachment 9)

FINDING

Progress notes were not documented according to the frequency requirements specified in the MHP contract. Below are the specific findings pertaining to the chart review sample:

- **Line numbers** [33]: For Mental Health Services claimed, the service activity (e.g., Assessment, Plan Development, Rehab) identified on the progress note was not

[33] Line number(s) removed for confidentiality

consistent with the specific service activity actually documented in the body of the progress note.

- **Line [34]**: Services provided on [35] and [36] were claimed as Collateral service, but documentation describes services more consistent with Mental Health Rehabilitation.

- **Line [37]**:
  - Services provided on [38] were claimed as Individual Rehabilitation Service, but the documentation describes services more consistent with Family Therapy.
  - Services provided on [39] were claimed as an Individual Rehabilitation Service, but the documentation describes services more consistent with Collateral services.
  - Services provided on [40] were claimed as Targeted Case Management. Progress notes for these services described Collateral services in which the case manager provided consultation to the parent or guardian regarding their interaction with the child beneficiary.

PLAN OF CORRECTION

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

1) Ensure that all progress notes:
   a) Are accurate, complete and meet the documentation requirements described in the MHP Contract with the Department.
   b) Describe the type of service or service activity, the date the service was provided and the amount of time taken to provide the service, as specified in the MHP Contract with the Department.
   c) Are completed within the timeline and frequency specified in the MHP Contract with the Department.

Provision of ICC and IHBS to Children and Youth:

REQUIREMENTS
The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth, and their families, at least every 90 days, and as needed. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

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[36] Date(s) removed for confidentiality
[37] Line number(s) removed for confidentiality
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FINDING 6B:

The medical record for the following Line number(s) did not contain evidence that the ICC Coordinator and the CFT had regularly met to reassess the strengths and needs of the beneficiary, at least every 90 days, for the purpose of determining if ICC and/or IHBS should be added or modified. Below are the specific findings pertaining to the chart review sample:

- **Line numbers [41].**
  - **Line number [42]:** Progress notes indicate that the beneficiary is receiving ICC services. Although there is mention of a plan to convene a CFT meeting, it is unclear from documentation if CFT meetings are being held, the frequency of meetings, the roles of participants in CFT meetings, etc.
  - **Line number [43]:** Progress notes included examples in which providers would meet with the caregiver, and/or other coordinating services. However, it is unclear if providers were conducting CFT meetings at least every 90 days. Meetings did not appear to include the beneficiary, which is a standard of CFT meetings.
  - **Line number [44]:** Progress notes included examples in which providers would meet with the caregiver and other coordinating services, but the child was not present for these meetings. CFT meetings, which include the beneficiary and family, should occur at least every 90 days as required.

PLAN OF CORRECTION

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

1) Written documentation is in place describing the policy and process for convening and conducting CFT meetings at least every 90-days for all beneficiaries receiving ICC and IHBS under the age of 21.
2) Training is provided to all staff and contracted providers who have the responsibility for determining eligibility and need for the provision of ICC and IBHS.
3) Each beneficiary receiving ICC and IHBS should be regularly reassessed to determine their continuing need and appropriate level of services.

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[42] Line number(s) removed for confidentiality
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