DEPARTMENT OF HEALTH CARE SERVICES
REVIEW OF LOS ANGELES MENTAL HEALTH PLAN
FEBRUARY 4-8, 2019
CHART REVIEW FINDINGS REPORT

Chart Review – Non-Hospital Services

The medical records of forty (40) adult and forty (40) 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 **1821** claims submitted for the months of **January, February** and **March** of **2018**.

Contents

Medical Necessity

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

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

RR1. 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 (FFP) in accordance with the covered diagnoses for reimbursement of outpatient and inpatient SMHS.

RR2. 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.

(MHSUDS IN No. 17-050, Enclosure 4)

FINDING 1A:
The MHP did not submit documentation substantiating the beneficiary met the medical necessity criteria for SMHS and their need for services was established by an assessment.

- **Line number [1].** The Initial Assessment was completed on [2], which was after the completion of the client plan on [3].

- **Line number [4].** Services were provided during the review period (January-March 2018), prior to the completion of the assessment on [5]. The diagnosis was entered into the record on [6], before the assessment was finalized.
  RR2, refer to Recoupment Summary for details.

PLAN OF CORRECTION 1A:
The MHP shall submit a POC that describes how the MHP will ensure that beneficiarys meet medical necessity criteria for SMHS services and their need for services is established by an assessment.

FINDING 1A-1:

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The medical record associated with the following Line number did not establish that the beneficiary met DSM criteria for an included ICD diagnosis for outpatient SMHS in accordance with the MHP contract:

- **Line number** [7]. The diagnosis was entered into the medical record before establishing that the beneficiary met DSM criteria. The diagnosis was entered into the medical record on [8]; however, the assessment was not finalized until [9]. **RR1a, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 1A-1:
The MHP shall submit a POC that describes how the MHP will ensure that only beneficiaries with an included mental health diagnosis have claims submitted for specialty mental health services (SMHS) in order to meet the medical necessity criteria contained in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R) for Medi-Cal reimbursement.

Assessment

REQUIREMENTS
The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation. (MHP Contract, Ex. A, Att. 9)
Reasons for Recoupment (RR): *Refer to the enclosed Recoupment Summary for additional details about disallowances.* RR2. 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. (MHSUDS IN No. 17-050, Enclosure 4)

FINDING 2A:
Assessments were not completed in accordance with State requirements, including the State Plan and MHP contract, specifically:

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

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[8] Date(s) removed for confidentiality
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- **Line numbers [10].** There was no initial assessment found in the medical record. **RR2, refer to Recoupment Summary for details.** *During the review, MHP staff were given the opportunity to locate missing assessments.*
  - **Line number [11]:** The current assessment is the Annual Assessment Update, completed [12]. The MHP was not able to locate the original assessment. Not all required elements are addressed in the current Annual Assessment Update.
  - **Line number [13]:** The MHP did not submit the Assessment required to establish and substantiate the beneficiary's need for services.

- **Line numbers: [14].** There was no updated assessment found in the medical record. The MHP policy for assessments includes updating the assessment every 3 years. *During the review, MHP staff were given the opportunity to locate missing assessments.*
  - **Line number [15]:** The current assessment is dated [16]. The updated assessment would have been due [17].
  - **Line number [18]:** The current assessment is dated [19]. The updated assessment would have been due [20].
  - **Line number [21]:** The current assessment is dated [22]. The updated assessment would have been due every three years.

- **Line numbers [23].** The initial assessment was completed late.
  - **Line number [24]:** The initial assessment was due on [25]. The assessment was completed on [26].

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- **Line number [27]:** The initial assessment was due on [28]. The assessment was completed on [29].

- **Line numbers [30].** The updated assessment was completed late.

  - **Line number [31]:** The signature date for the prior assessment could not be determined and therefore, could not be used to assess the timeliness of the current assessment. Based on the information documented regarding the client's age during the prior assessment, the current assessment dated [32], was found to be late.

  - **Line number [33]:** The prior assessment is dated [34]. The updated assessment would have been due [35]; however, the current assessment is dated [36].

b) The MHP did not furnish evidence it completes Assessments for TCM on an annual basis or at a shorter interval as appropriate, for those beneficiaries receiving Targeted Case Management (TCM) services (State Plan, Supplement 1 to Attachment 3.1-A).

The MHP submitted the Short Doyle/Medi-Cal Organizational Provider's Manual for SMHS under the Rehabilitation Option and Targeted Case Management Services, Effective July 1, 1993 and Updated February 17, 2017 as evidence of compliance. However, the MHP's policy for Assessment (Targeted Case Management on page 28 and page 40 of this manual) does not address the frequency requirement for TCM assessment, as stated in the State Plan.

- **Line numbers: [37].**

PLAN OF CORRECTION 2A:

The MHP shall submit a POC that:

1) 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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2) Describes how the MHP will ensure that assessments are completed on an annual basis or at a shorter interval as appropriate, for those beneficiaries receiving Targeted Case Management services.

3) Provides evidence that the MHP has written documentation standards for the reassessment of TCM that conform with the timeliness requirements required in the State Plan.

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 2B:

One or more of the assessments reviewed did not address all of the elements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

- Presenting Problem(s). **Line number [38].**
    - **Line number [39]:** The current re-assessment describes the reason for referral as "Same as Full Assessment," dated [40]. The full assessment indicated the beneficiary required a more comprehensive level of care, including medication management, psychotherapy and TCM. The re-assessment indicates the beneficiary is able to manage being a student including "demanding coursework" and "large commute." The reason for continued services, such as continued TCM, is not clear.
- Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health, including history of trauma. **Line numbers: [41].**
    - **For example: Line number [42]:** The writer documented "[when] symptoms of depression increase, client isolates, feelings of hopelessness increase and consumes alcohol. Client looks for employment on a daily basis." The precursory conditions leading up to/ triggering depressive episodes is not clear. The frequency and current impact of these episodes on the beneficiary's ability to function in their daily life is not clear.
- Mental Health History. **Line numbers: [43].**
    - **For example: Line numbers [44]:** The re-assessment documents, "Tri-annual – Same as full assessment." The re-assessment does not describe current status or notable impact, if any, of SMHS interventions provided to the beneficiary since the last assessment.
    - **Line number [45]:** The content of the Annual Assessment Update document does not describe current status or notable impact, if any, of SMHS interventions provided to the beneficiary since the last assessment.

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- Medical History. **Line numbers: [46].**
    - **For example: Line number [47]:** The re-assessment content includes a box checked "No updates," suggesting the beneficiary has not had any physical health events over the last 3 years. This section is not consistent with the statement made in the Chief Complaint section, "Client's symptoms are often exacerbated by ongoing physical pain."
    - **Line number [48]:** Documentation consists of "N/A" and a check box indicates No Updates. There is no description of the beneficiary's current physical health.
- Medications. **Line numbers: [49].**
- Substance Exposure/Substance Use. **Line numbers: [50].**
    - **For example: Line number [51]:** In addition to checking the box "No updates," the Substance Use/Abuse section included a notation "Client has no hx of substance use/abuse." This notation is specific to historical factors and does not address current behavior.
    - **Line number [52]:** There is not an adequate discussion of the beneficiary's current substance use and the impact, if any, on the beneficiary's symptom presentation and functional impairments.
    - **Line number [53]:** Documentation consists of "NA" and a check box indicates No Updates. There is no indication that the beneficiary was asked about current substance use.
- Client Strengths. **Line numbers [54].**
- Risks. **Line numbers: [55].**
    - **For example: Line number [56]:** The Psychiatric Evaluation submitted [57] did not include risks.
    - **Line number [58]:** The sections of the assessment addressing risk (i.e., Suicidal/Homicidal Thought/Attempts, Self-Harm, Trauma or Exposure to Trauma, Substance Use/Abuse, etc.) were completed with a notation of "No updates." There does not appear to be a current assessment of the beneficiary's risk factors, although the beneficiary has a clinically significant condition of Major Depressive Disorder.

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- **Line number [59]:** The sections of the re-assessment dealing with risk (i.e., Suicidal/Homicidal Thought/Attempts, Trauma or Exposure to Trauma, and Substance Use/Abuse) were completed with a notation of "No updates." The Self-Harm section included a notation "Chronic suicidality, no plan/intent." The Full Assessment dated [60], referenced in the re-assessment, documented that the "Client will isolate due to pain and difficulty walking and frequently states that she wants to 'leave' her body or is 'tired of this body." The beneficiary has a mental health condition of Major Depressive Disorder and an apparent chronic pain condition; an updated risk assessment would be clinically indicated.
- **Line number [61]:** The beneficiary has a history of suicide attempts. The writer documented NA and checked the box for No Updates under the Suicidal/Homicidal Thoughts/Attempts section of the re-assessment. There are boxes checked for No Updates in sections Self-Harm and Trauma or Exposure to Trauma, with "None reported," written in each section. The risk assessment is not sufficiently documented. There is no indication that the beneficiary was asked about risk factors.

- A mental status examination. **Line numbers: [62].**
- A full diagnosis from the current ICD code. **Line numbers [63].**
  - **Line number [64]:** The assessment content contains a history of symptoms embedded with current symptoms: it is not clear which diagnostic criteria are current. The re-assessment contains a section for clinical formulation and diagnostic justification; however, this section does not document the current diagnosis. The link to a previously determined diagnosis is not clearly stated in the re-assessment document.

    Note: During the onsite portion of the triennial review, the MHP described their assessment practice, including pairing the original Full Assessment document with re-assessments. In this process, updates are usually made to elements that are no longer current.
  - **Line number [65]:** The current assessment is the Annual Assessment Update, completed [66]. The description of the beneficiary's mental health condition and the impact this condition has on the beneficiary's ability to function is not sufficiently detailed in the updated assessment. There is not an adequate discussion of the beneficiary's substance use and the impact, if any, on the beneficiary's symptom presentation and functional impairments.The current mental status of the beneficiary is not present in the updated assessment

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document. The document does not provide content for history/interim history of mental health treatment/interventions, history of trauma/current trauma exposure, current medications (if any), risk factors specific to the client, and current protective factors.There is no mention of psychosis in the updated assessment; yet, the treatment plan notes the presence of psychosis.

- History of trauma. **Line numbers: [67].**

PLAN OF CORRECTION 2B:

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

REQUIREMENTS
All entries in the beneficiary record shall include: 1) The date of service. 2) The signature of the person providing the service (or electronic equivalent). 3) The type of professional degree, licensure, or job title of the person providing the service. 4) The date the documentation was entered in the medical record. (MHP Contract, Ex. A, Attachment 9)

FINDINGS 2C:

Assessment(s) in the chart sample did not include the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title, or the date the documentation was entered into the medical record. Below are the specific findings pertaining to the charts in the review sample:

- Signature of the person providing the service (or electronic equivalent).
  - **Line number [68]:** There is an unsigned Adult Assessment Addendum note dated [69] in the record.
- The type of professional degree, licensure, or job title of person providing the service.
  - **Line number [70]:** The Community Functioning Evaluation dated [71], documented the signature without the degree, license, or job title of the person providing the service.

PLAN OF CORRECTION 2C:

[67] Line number(s) removed for confidentiality
[68] Line number(s) removed for confidentiality
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[70] Line number(s) removed for confidentiality
[71] Date(s) removed for confidentiality

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

1) The signature of the qualified person (or electronic equivalent) with the professional degree, licensure or job title of the person providing the service.
2) The signature date indicating the document was completed and entered into the medical record.

Medication Consent

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

FINDING 3A:

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, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent.

- **Line numbers [72]**: There was no written medication consent form found in the medical record. *The MHP was unable to submit all required medication consent documentation, as required.*
- **Line numbers [73]**: The written medication consent form was not signed by the beneficiary.
- **Line number [74]**: Although there was a written medication consent form in the medical record, there was no medication consent for each of the medications prescribed. *The MHP was unable to submit all required medication consent documentation, as required.*

PLAN OF CORRECTION 3A:

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

1) The MHP shall require providers to obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of each psychiatric medication administered under the direction of the MHP.
2) Written medication consent forms are completed in accordance with the MHP's written documentation standards and the MHP Contract with the Department.

REQUIREMENTS

[72] Line number(s) removed for confidentiality
[73] Line number(s) removed for confidentiality
[74] Line number(s) removed for confidentiality

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 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 on the medication consent form, and/or documented to have been reviewed with the beneficiary:

1) The reason for taking each medication. **Line numbers [75].**

2) Reasonable alternative treatments available, if any. **Line numbers: [76].**

3) Type of medication. **Line numbers: [77].**

4) Range of Frequency. **Line numbers: [78].**

5) Dosage. **Line numbers: [79].**

6) Method of administration (oral or injection). **Line numbers: [80].**

7) Duration of taking each medication. **Line numbers: [81].**

8) Probable side effects. **Line number 8.**

9) Possible side effects if taken longer than 3 months. **Line numbers: [82].**

10) Consent once given may be withdrawn at any time. **Line numbers: [83].**

PLAN OF CORRECTION 3B:

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[77] Line number(s) removed for confidentiality
[78] Line number(s) removed for confidentiality
[79] Line number(s) removed for confidentiality
[80] Line number(s) removed for confidentiality
[81] Line number(s) removed for confidentiality
[82] Line number(s) removed for confidentiality
[83] Line number(s) removed for confidentiality

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

REQUIREMENTS
All entries in the beneficiary record shall include: 1) The date of service. 2) The signature of the person providing the service (or electronic equivalent). 3) The type of professional degree, licensure, or job title of the person providing the service. 4) The date the documentation was entered in the medical record. (MHP Contract, Ex. A, Attachment 9)

Finding 3C:
Medication Consent(s) in the chart sample did not include the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title, or the date the documentation was entered into the medical record. Below are the specific findings pertaining to the charts in the review sample:

- Signature of the person providing the service (or electronic equivalent).
  - **Line number [84].**

- The type of professional degree, licensure, or job title of person providing the service.
  - **Line numbers: [85].**

PLAN OF CORRECTION 3C:
The MHP shall submit a POC that describes how the MHP will ensure that all documentation includes**:**

1) The signature of the qualified service provider (or electronic equivalent) with their professional degree, licensure or title.

2) The service provider signature date/ the date the document was completed and entered into the medical record.

Client Plans

REQUIREMENTS

[84] Line number(s) removed for confidentiality
[85] Line number(s) removed for confidentiality

Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. Services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary. (MHP Contract, Ex. A, Attachment 2)
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)
Reasons for Recoupment (RR): ***Refer to the enclosed Recoupment Summary for additional details about disallowances.*** RR4. 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. (MHSUDS IN No. 17-050, Enclosure 4)

FINDING 4B:

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 as specified in the MHP's documentation standards). Below are the specific findings pertaining to the charts in the review sample.

- The initial client plan was not completed until after treatment services were claimed. **Line numbers [86]. RR4a, refer to Recoupment Summary for details.**
- 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. **Line number [87]. RR4b, refer to Recoupment Summary for details.**
  - **Line number [88]:** The client plan dated [89] was no longer in effect on [90]. The subsequent client plan became effective on [91].

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- There was a **lapse** between the prior and current client plans; however, this occurred outside of the audit review period. **Line numbers: [92]**.
  - **Line number [93]:** The prior plan expired [94]. The current plan was in effect [95].
  - **Line number [96]:** The prior plan expired [97]. The current plan was in effect [98].
  - **Line number [99]:** The prior plan expired [100]. The current plan was in effect [101].
  - **Line number [102]:** The prior plan expired [103]. The current plan was in effect [104].
  - **Line number [105]:** The prior plan expired [106]. The current plan was in effect [107].

- The medical record indicated an acute change in the beneficiary's mental health status (e.g. hospitalized, suicide attempt, multiple crisis intervention encounters, etc.); however, no evidence was found in the medical record that the client plan was reviewed and/or updated in response to the change. **Line numbers: [108].**
  - **Line number [109]:**
    - Documentation in the medical record stated the case manager and hospital staff engaged in discharge planning on [110], after the beneficiary had been voluntarily admitted for suicidal ideation with a plan and method. The psychiatric assessment update, dated [111], included treatment recommendations, to hold off refilling medications until the beneficiary was "clean and sober." There was no evidence to support that the treatment plan was reviewed and updated accordingly.
    - Documentation in the medical record stated the LVN was working on discharge planning from a convalescent hospital on [112], and was coordinating for follow up services. There was no evidence to support that the treatment plan was reviewed and updated accordingly.

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- **Line number [113]:** The medication support progress note from [114] documented the beneficiary would be going to a rehabilitation program to address significant substance abuse concerns.The client plan dated [115] was nearly identical to the previous client plan dated [116], and did not appear to have been updated following the change in the beneficiary's mental health status.
- **Line number [117]:** The beneficiary received multiple crisis interventions, TBS interventions, and had a suicide attempt without any evidence of an update to the client plan as a result of these acute events.

- There was **no** client plan for one or more type of service being claimed. During the review, MHP staff was given the opportunity to locate the service(s) in question on a client plan but could not find the supporting documentation. **Line numbers: [118]. RR4c, refer to Recoupment Summary for details**
  - **Line number [119]:** Targeted Case Management services were claimed for follow up and monitoring activities; however, TCM services were not added to the client plan until [120], after these services were received.
  - **Line number [121]:** Medication Support Services were claimed; however, there was no plan in effect for these services. The client plan dated [122] did not include medication support services. The prior client plan, which included medication support services, was no longer in effect.
  - **Line number [123]:** Targeted Case Management services (i.e. monitoring) were provided; however, TCM services were not on the current plan dated [124].
  - **Line number** [125]**:** Rehabilitation Services were not on the client plan until [126].
  - **Line number** [127]**:** Day Rehabilitation Services were not on the client plan.
  - **Line number [128]:** Progress note interventions describe case management services that were not on the client plan.

PLAN OF CORRECTION 4B:

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

[113] Line number(s) removed for confidentiality
[114] Date(s) removed for confidentiality
[115] Date(s) removed for confidentiality
[116] Date(s) removed for confidentiality
[117] Line number(s) removed for confidentiality
[118] Line number(s) removed for confidentiality
[119] Line number(s) removed for confidentiality
[120] Date(s) removed for confidentiality
[121] Line number(s) removed for confidentiality
[122] Date(s) removed for confidentiality
[123] Line number(s) removed for confidentiality
[124] Date(s) removed for confidentiality
[125] Line number(s) removed for confidentiality
[126] Date(s) removed for confidentiality
[127] Line number(s) removed for confidentiality
[128] Line number(s) removed for confidentiality

1) Ensure that client plans are completed prior to provision of planned services.
2) 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.
3) Ensure that planned services are not claimed when the service provided is not included in the current client plan.
4) Ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

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)

FINDING 4C:
Client Plans did not include all of the required elements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

- 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: [129].**
    - **For example: Line number [130]:** The [131] client plan includes the goal "Reduce the level of vigilance around others" with the objective "Report a decrease in paranoid symptoms due to the regular use of psychiatric medications." Although the plan objective appears to be a quantifiable medication support objective (e.g. medication adjustment), the interventions consist of psychoeducation, deep breathing, and distraction techniques.

[129] Line number(s) removed for confidentiality
[130] Line number(s) removed for confidentiality
[131] Date(s) removed for confidentiality

- A second goal on the same plan is "Learn coping skills to reduce effects of hallucinations or delusions" with the objective "To reduce the frequency and intensity of auditory hallucinations from every day to 3 times per day." Although the medication support services is measurable, the intervention is not skill-based as would be expected from the goal statement (i.e. "Learn coping skills…").

- **Line number [132]:** On the [133] client plan, there is an objective which is specific to substance abuse and relapse prevention. The selected category for interventions is mental health services; however, the description clearly indicates the focus is substance abuse education (identification of triggers for substance abuse and gaining insight into substance use effects on mental health), and the development of a plan for relapse prevention.

- 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. **Line numbers: [134].**

  - **Line number [135]:** The description details under the MHS Intervention are specific to TCM activities and not MHS activities.

  - **Line number [136]:** On the [137] client plan, there is an objective to address sympoms of depression, which is signed by an MD. Medication Support Services would appear to be the implied service intervention category, but this is not expressly stated in the plan.

  - **Line number [138]:**

    - On the [139] client plan, the Targeted Case Management objective is written "Decrease symptoms of depression…Impairs his ability to care for activities of daily living as he is unable to complete responsibilities needed for independent living." This objective would appear to be consistent with Mental Health Services.
    - The interventions listed under the TCM objective include "Staff will link participant with resources such as social services, public transportation, provide needed referrals, and assist with transitional living arrangements including paperwork and transportation." The use of language "such as" followed by a list, and the use of the language "needed referrals" is not

[132] Line number(s) removed for confidentiality
[133] Date(s) removed for confidentiality
[134] Line number(s) removed for confidentiality
[135] Line number(s) removed for confidentiality
[136] Line number(s) removed for confidentiality
[137] Date(s) removed for confidentiality
[138] Line number(s) removed for confidentiality
[139] Date(s) removed for confidentiality

specific and does not clearly match up to the identified needs and impairments identified in the beneficiary's assessment.

- One or more of the proposed interventions did not indicate an expected frequency. **Line numbers: [140].**
- One or more of the proposed interventions did not indicate an expected duration. **Line numbers: [141].**
- One or more client plans did not address the mental health needs and functional impairments identified as a result of the mental disorder. **Line numbers: [142].**
    - **Line number [143]:** Objective #1 states, "Decrease SI from daily to no SI for greater than 3 months." However, the Assessment indicates the client denies current suicidal ideation and makes only a brief reference to history of SI.
    - **Line number [144]:** Assessment addresses anxiety related to medical trauma and recommends support with anxiety in medical settings; however this is not specifically addressed in the treatment plan.
    - **Line number [145]:** Beneficiary is diagnosed with Major Depressive Disorder, recurrent and only one intervention addressing their condition is on the client plan.
- One or more client plans were not consistent with the qualifying diagnosis. **Line numbers [146].**
    - **Line number [147]:** The client plan included TCM and Medication Support services. However, the plan did not include Mental Health Services (e.g. Therapy) intervention(s) which would be clinically indicated to address the functional impairments resulting from Major Depressive Disorder.
    - **Line number [148]:** The content of the [149] client plan is nearly identical to the content of the [150] client plan. It is not clear that the plan meets the needs of the beneficiary, by adequately addressing the functional impairments resulting from Major Depressive Disorder.

PLAN OF CORRECTION 4C:

[140] Line number(s) removed for confidentiality
[141] Line number(s) removed for confidentiality
[142] Line number(s) removed for confidentiality
[143] Line number(s) removed for confidentiality
[144] Line number(s) removed for confidentiality
[145] Line number(s) removed for confidentiality
[146] Line number(s) removed for confidentiality
[147] Line number(s) removed for confidentiality
[148] Line number(s) removed for confidentiality
[149] Date(s) removed for confidentiality
[150] Date(s) removed for confidentiality

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.
5) All client plans are consistent with the qualifying diagnosis.

REQUIREMENTS
The MHP shall ensure that Client Plans include documentation of the beneficiary's participation in and agreement with the Client Plan. (MHP Contract, Ex. A, Att. 9; CCR, title 9, § 1810(c)(2).)
The MHP shall ensure that Client Plans include the beneficiary's signature or the signature of the beneficiary's legal representative when: a) The beneficiary is expected to be in long-term treatment, as determined by the MHP, and, b) The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS. (CCR, title 9, § 1810.440(c)(2)(A).)
When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan includes a written explanation of the refusal or unavailability of the signature. (CCR, title 9, § 1810.440(c)(2)(B).)
The MHP shall have a written definition of what constitutes a long-term care beneficiary. (MHP Contract, Ex. A, Att. 9)

FINDING 4E:
There was no documentation of the beneficiary's or the legal representative's degree of participation in and agreement with the client plan; and, there was no written explanation of the beneficiary's refusal or unavailability to sign the plan, if the signature was required as per

the MHP Contract with the Department and/or by the MHP's written documentation standards**:**

- The beneficiary or the legal representative was required to sign the client plan per the MHP Contract with the Department (i.e., the beneficiary is in "long-term" treatment and receiving more than one type of SMHS), and/or per the MHP's written documentation standards. However, the signature was missing. **Line numbers: [151].**
    - **Line number [152]:** There is a co-occurring medication support plan dated [153], which was not signed by beneficiary. The plan content indicates the beneficiary will sign at next appointment; however, the MHP did not submit evidence of the beneficiary signature.
    - **Line number [154]:** The MHP did not submit evidence to show the beneficiary signature or refusal/unavailability to sign the client plan dated [155].

PLAN OF CORRECTION 4E:
The MHP shall submit a POC that describes how the MHP will ensure that the beneficiary's signature is obtained on the client plan, as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2)(A)(B).

REQUIREMENTS
There is documentation in the Client Plan that a copy of the Client Plan was offered to the beneficiary.

FINDING 4G:
There was no documentation that the beneficiary or legal guardian was offered a copy of the client plan. This requirement was not addressed on the client plan and the MHP did not provide evidence that a copy of the plan was offered to the beneficiary.

Line numbers: [156].

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

1) Ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan.
2) Submit evidence that the MHP has an established process to ensure that the beneficiary is offered a copy of the client plan.

[151] Line number(s) removed for confidentiality
[152] Line number(s) removed for confidentiality
[153] Date(s) removed for confidentiality
[154] Line number(s) removed for confidentiality
[155] Date(s) removed for confidentiality
[156] Line number(s) removed for confidentiality

REQUIREMENTS
All entries in the beneficiary record (i.e., Client Plans) include: 1) Date of service. 2) The signature of the person providing the service (or electronic equivalent); 3) The person's type of professional degree, licensure or job title. 4) Relevant identification number (e.g., NPI number), if applicable. 5) The date the documentation was entered in the medical record. (MHP Contract, Ex. A, Att. 9)

FINDING 4H:
Client Plan(s) in the chart sample did not include the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title. Below are the specific findings pertaining to the charts in the review sample:

- Signature of the person providing the service (or electronic equivalent). **Line number [157].**

- The type of professional degree, licensure, or job title of person providing the service. **Line numbers: [158].**

PLAN OF CORRECTION 4H:
The MHP shall submit a POC that describes how the MHP will ensure that all documentation includes the signature (or electronic equivalent) and the professional degree, licensure or title of the person providing the service.

Progress Notes

REQUIREMENTS

[157] Line number(s) removed for confidentiality
[158] Line number(s) removed for confidentiality

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)

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

RR5. 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.

RR7. 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.

RR8. 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:
1) Specialty Mental Health Service claimed.
2) Date of service, and/or
3) Units of time.

RR15. The MHP did not submit documentation that a valid service 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.

(MHSUDS IN No. 17-050, Enclosure 4)

FINDING 5B:

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

- The progress note did not describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning. **Line numbers: [159]. RR7, refer to Recoupment Summary for details.**

[159] Line number(s) removed for confidentiality

- **Line number [160]:** The progress note is claimed as a mental health service and addresses a plan of "continuing to consult" with a second provider with no further detail about how the services reduced the beneficiary's impairment.

- **Line number [161]:** The progress note addresses substance abuse issues.

- The focus of the intervention did not address the beneficiary's functional impairment resulting from the beneficiary's mental health condition. **Line number [162]. RR5a, refer to Recoupment Summary for details.**

- Progress notes associated with the following line number(s) did not include timely documentation of relevant aspects of beneficiary's care, as specified by the MHP's written documentation standards in effect during the audit period. According to Policy No. 401.02 – Clinical Records, Maintenance, Organization, and Contents, "All clinical documentation…must be completed and finalized or scanned into the EHR by the end of the next scheduled work day following the delivery of service unless specific exception is made by the program manager or their designee prior to submission of claims for reimbursement."

  Line numbers: [163].

- 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. **Line numbers [164].**

  - **Line number [165]:** The MHP provided a supplemental log of dates for when the progress notes were submitted to the medical record. Sixteen of the twenty-four notes were found to be late based on the MHP's policy for completing documentation "…by the end of the next scheduled work day following the delivery of service…"

  - **Line number [166]:** Eighty-five electronically signed daily adult residential notes did not include the signature date, the date of entry into the medical record.

Note: *Every "Clinitrak" progress note in the CLAIMS sample during this audit period, had a date of entry which was the same as the date of service.* ***Line numbers [167].***

[160] Line number(s) removed for confidentiality
[161] Line number(s) removed for confidentiality
[162] Line number(s) removed for confidentiality
[163] Line number(s) removed for confidentiality
[164] Line number(s) removed for confidentiality
[165] Line number(s) removed for confidentiality
[166] Line number(s) removed for confidentiality
[167] Line number(s) removed for confidentiality

- Documentation of follow-up care or, as appropriate, a discharge summary. **Line number [168].**
    - **Line number [169]:** The beneficiary was hospitalized for suicidal ideation and visual hallucinations on [170]. Post-hospitalization progress note on [171] states that client has not obtained a prescription for anti-psychotic medication. No evidence of care coordination with the discharging hospital.
- The units of time documented for services claimed. The progress note in the medical record documented the date of the service claimed; however, the units of time documented were less than the units of time claimed or were not documented. **Line number [172]. RR8b3, refer to Recoupment Summary for details.**
- More than one service type/category documented and one service type/category claimed, without specifically documenting the amount of time for each service. **Line number [173]. RR8b3, refer to Recoupment Summary for details**.
    - **Line number [174]:** The progress notes corresponding to claims dated [175] SF30 for 70 minutes and [176] SF30 for 108 minutes, include documentation of both TCM and Therapy interventions. The amount of time taken to provide each service type was not clearly documented on the progress note.
- The provider's professional degree, licensure or job title. **Line numbers: [177].**
    - **Line number [178]:** The weekly summary notes did not contain the provider's professional degree, licensure or job title.
- The appointment was missed or cancelled. **Line number [179]. RR15a, refer to Recoupment Summary for details.**
- The service provided did not meet the applicable definition of a SMHS. **Line numbers: [180]. RR15b, refer to Recoupment Summary for details.**
    - **Line number [181]:** Therapist billed two Plan Development services for contacting DCFS to report child abuse.

[168] Line number(s) removed for confidentiality
[169] Line number(s) removed for confidentiality
[170] Date(s) removed for confidentiality
[171] Date(s) removed for confidentiality
[172] Line number(s) removed for confidentiality
[173] Line number(s) removed for confidentiality
[174] Line number(s) removed for confidentiality
[175] Date(s) removed for confidentiality
[176] Date(s) removed for confidentiality
[177] Line number(s) removed for confidentiality
[178] Line number(s) removed for confidentiality
[179] Line number(s) removed for confidentiality
[180] Line number(s) removed for confidentiality
[181] Line number(s) removed for confidentiality

- The exact same verbiage was recorded on multiple progress notes; therefore, those progress notes were not individualized and did not accurately document the service encounter, as specified in the MHP Contract with the Department for: **Line number [182].**

    - **Line number [183]:** The note content for services dated [184] SF30 for 60 minutes is word for word the same as the note content for service dated [185] SF30 for 60 minutes, with exception of the beneficary's verbal response (duplicative). **RR7, refer to Recoupment Summary for details.**

- The completion of the same specific service activity (i.e. Community Functioning Evaluation) was recorded on consecutive progress notes; therefore, a portion of the note content is duplicative. When content is duplicative across progress notes, it is not clear that the service was not included with the total minutes claimed. **Line Number [186].**

    - Specifically, the service intervention noted on [187] SF1 for 85 minutes included the activity of having completed the Community Functioning Evaluation; and, the service intervention on [188] SF1 for 95 minutes, included the activity of having completed the Community Functioning Evaluation (duplicative).

PLAN OF CORRECTION 5A:

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.
    - Beneficiary encounters, including relevant clinical decisions, when decisions are made, and alternative approaches for future interventions, as specified in the MHP Contract with the Department.
    - Interventions applied, the beneficiary's response to the interventions and the location of the interventions, as specified in the MHP Contract with the Department.

[182] Line number(s) removed for confidentiality
[183] Line number(s) removed for confidentiality
[184] Date(s) removed for confidentiality
[185] Date(s) removed for confidentiality
[186] Line number(s) removed for confidentiality
[187] Date(s) removed for confidentiality
[188] Date(s) removed for confidentiality

- Ensure progress note matches the date the services were provided.
- Follow-up care and, if appropriate, a discharge summary, as specified in the MHP Contract with the Department.
- The claim must accurately reflect the amount of time taken to provide services and each service type.
- The provider(s)' professional degree, licensure or job title.

2) Documentation is individualized for each service provided.

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).

5) Speciality Mental Health Services claimed are actually provided to the beneficiary.

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, § 1840.314(c).)
Reasons for Recoupment (RR): *Refer to the enclosed Recoupment Summary for additional details about disallowances.* RR13. 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 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. (MHSUDS IN No. 17-050, Enclosure 4)

FINDING 5C:

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.

- Progress note(s) did not document the specific involvement of each provider in the context of the mental health needs of the beneficiary. **Line numbers: [189]. RR13a, refer to Recoupment Summary for details.**
    - **Line number [190]:** The progress note for service dated [191] SF30 for 42 minutes documented only one staff member's contribution. Throughout this record, the progress notes lack clear documentation of the contribution of each staff in a group setting.
    - **Line number [192]:** The progress note for service dated [193] SF1 for 100 minutes documented only one staff member's contribution. The specific involvement and contribution of the COD Counselor (40 minutes face to face) is not clearly documented.
    - **Line number [194]:** The progress notes for services dated [195] SF30 for 197 minutes and [196] SF30 for 270 minutes, each document only one staff member's contribution. The co-facilitator's involvement and contribution with each of these services is not clearly documented.
- Progress notes documented "co-facilitation" or "therapists" but only one provider was noted as present during the group service. **Line number [197].**
- Progress notes did not document the specific amount of time of involvement of each provider, including travel and documentation time, if appropriate. **Line number [198]. RR13b, refer to Recoupment Summary for details.**
    - **Line number [199]:** The progress note for service appointment dated [200] SF30 for 70 minutes documented the Community Worker's face-to-face time as 60 minutes. The MD progress note for the same service appointment documented face-to-face time as 30 minutes. The content of the Community Worker note does not account for the additional 30 minutes of face-to-face time claimed outside of the MD appointment.

PLAN OF CORRECTION 5C:

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

[189] Line number(s) removed for confidentiality
[190] Line number(s) removed for confidentiality
[191] Date(s) removed for confidentiality
[192] Line number(s) removed for confidentiality
[193] Date(s) removed for confidentiality
[194] Line number(s) removed for confidentiality
[195] Date(s) removed for confidentiality
[196] Date(s) removed for confidentiality
[197] Line number(s) removed for confidentiality
[198] Line number(s) removed for confidentiality
[199] Line number(s) removed for confidentiality
[200] Date(s) removed for confidentiality

1) 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.
2) 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.
3) A clinical rationale for the use of more than one staff in the group setting is documented.

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)

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

RR8. 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:
1) Specialty Mental Health Service claimed.
2) Date of service, and/or
3) Units of time.

(MHSUDS IN No. 17-050, Enclosure 4)

FINDING 5D:
Progress notes were not documented according to the frequency requirements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample.

- There was no progress note in the medical record for the service claimed. **Line numbers [201]. RR8a, refer to Recoupment Summary for details**. *The MHP was given the opportunity to locate the documents in question but were unable to retrieve the supporting documentation in the medical record.*
- The type/category of specialty mental health service (e.g., Mental Health Services, Medication Support, Targeted Case Management, etc.) documented on the progress note was not the same type of SMHS claimed. **Line numbers: [202]. RR8b1, refer to Recoupment Summary for details.**
    - **Line number [203]:** Progress notes documented case management and were claimed as mental health services.
    - **Line number [204]:** Progress note documented linkages to services and were claimed as a mental health service.
    - **Line number [205]:** Progress note documented case management and was claimed as a mental health service.
    - **Line number [206]:** Progress notes documented case management and were claimed as mental health services.

[201] Line number(s) removed for confidentiality
[202] Line number(s) removed for confidentiality
[203] Line number(s) removed for confidentiality
[204] Line number(s) removed for confidentiality
[205] Line number(s) removed for confidentiality
[206] Line number(s) removed for confidentiality

- For Mental Health Services claimed, the service activity (e.g., Assessment, Plan Development, Rehabilitation, etc.) identified on the progress note was not consistent with the service activity documented in the body of the progress note. **Line numbers: [207].**

    - **Line number [208]:** Progress note dated [209] describes a collateral service and was identified as Individual Rehabilitation. Progress note dated [210] describes a plan development service and was identified as Individual Rehabilitation.

    - **Line number [211]:** Progress notes dated [212] and [213] describe assessment and were identified as Individual Therapy.

    - **Line number [214]:** Progress note dated [215] identified as case consultation is a collateral service activity.

PLAN OF CORRECTION 5D:

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 billing code, and units of time.
2) Ensure that all progress notes 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.

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

[207] Line number(s) removed for confidentiality
[208] Line number(s) removed for confidentiality
[209] Date(s) removed for confidentiality
[210] Date(s) removed for confidentiality
[211] Line number(s) removed for confidentiality
[212] Date(s) removed for confidentiality
[213] Date(s) removed for confidentiality
[214] Line number(s) removed for confidentiality
[215] Date(s) removed for confidentiality

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

FINDING 5E:
Documentation in the medical record did not meet the following requirements:

- One of the service activities documented in the progress note was not within the scope of practice of the person delivering the service. **Line number [216].**
    - **Line number [217]:** While the Rehabilitation service activity provided on [218] SF30 for 125 minutes, was within the scope of practice of the person signing the progress note, a component of the service documentation was not, specifically the Mental Status Examination and Diagnosis. The MHP reported, "*Per the provider, the MSE and Diagnosis came from the previous assessment performed on the same day by [sic], PhD.*"

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

1) 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.
2) Staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.

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

RR11. 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

(MHSUDS IN No. 17-050, Enclosure 4)

[216] Line number(s) removed for confidentiality
[217] Line number(s) removed for confidentiality
[218] Date(s) removed for confidentiality

FINDING 5E2:

The progress note(s) for the following Line number(s) indicate that the service provided was solely clerical. **Line numbers: [219]. RR11f, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5E2:

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 clerical.

REQUIREMENTS
The MHP must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

FINDING 6A:

- The MHP did not furnish evidence that it has a standard procedure for providing individualized determinations of eligibility for ICC services and IHBS for beneficiaries under 22 years of age that is based on their strengths and needs.

- The medical record did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS.

Line numbers: [220]. Individualized determinations of each child's need for ICC and IHBS services was not made based on their strengths and needs. Based on information provided in the assessments, these beneficiaries may benefit from ICC/IHBS services. For example:

- **Line number [221]:** This 11 year-old child is multi-diagnosed and prescribed 3 psychotropic medications. Progress note dated [222] from Pacific Clinics reports, "Within the past year client has been stagnant in therapy. Client has not made much progress…" Client was transferred to FSP." Following transfer to FSP, client was receiving individual, family, collateral, and case management services.

[219] Line number(s) removed for confidentiality
[220] Line number(s) removed for confidentiality
[221] Line number(s) removed for confidentiality
[222] Date(s) removed for confidentiality

- **Line number [223]:** During the review period, 13 services (from [224] to [225]) were billed and all services were provided without the beneficiary present. The services billed attempted to link the client to services. The beneficiary was not connected to services until [226].

PLAN OF CORRECTION 6A:

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

1) Written documentation is in place describing the process for determining and documenting the eligibility and need for ICC and IHBS.
2) Training is provided to all staff and contracted providers who have the responsibility for determining the eligibility and need for the provision of ICC and IBHS.
3) Each beneficiary under the age of 22 who is authorized to receive Specialty Mental Health Services (SMHS) also receives an individualized determination of eligibility and need for ICC and IHBS prior to or during the development of the benficiary's Initial Client Plan.

REQUIREMENTS
Each participating provider in a CFT meeting may claim for the time they have contributed to the CFT meeting, up to the length of the meeting, plus documentation and travel time, in accordance with CCR, tit. 9, § 1840.316(b)(3). (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

FINDING 6E:

One or more claims was submitted for a Mental Health Service (Service Function "30") but the progress note(s) associated with the date(s) and time(s) claimed indicated that the service provided was actually for participation in an ICC "team" meeting, or for providing another ICC-specific service activity, and should have been claimed as an ICC case management service (Service Function "07"). **Line number [227].**

- **Line number [228]: "**Case consultation notes" were claimed as mental health services (SF 30), however they describe ICC functioning and should be coded (SF 07).

PLAN OF CORRECTION 6E:

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

1) The service activity described in the body of all progress notes is consistent with the specific service activity claimed - i.e., all claims submitted must be accurate and

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[225] Date(s) removed for confidentiality
[226] Date(s) removed for confidentiality
[227] Line number(s) removed for confidentiality
[228] Line number(s) removed for confidentiality

consistent with the actual service provided in terms of type of service, date of service and time of service.

Documentation of Cultural and Linguistic Services

REQUIREMENTS
The MHP shall make oral interpretation, available and free of charge for any language. (42 C.F.R. § 438.10(d)(2), (4)-(5).)
Items that shall be contained in the client record (i.e., progress notes) 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; (MHP Contract, Ex. A, Attachment 9)

FINDING 7A:
The medical record did not include evidence that oral interpretation services were made available to the beneficiary and/or the beneficiary's parent(s)/legal guardian(s). Progress notes lack relevant aspects of beneficiary care. Below are the specific findings pertaining to the charts in the review sample:

- **Line numbers: [229].** There was no evidence in the medical record that interpretation services were offered or provided to the beneficiary and/or the beneficiary's parent or legal guardian.
    - **Line number [230]:** The preferred language for the caregiver is Cambodian. The progress note documentation shows accommodation for only one of the services received.
    - **Line numbers [231]:** Accommodation to the beneficiary for Cambodian language preference was not documented.

PLAN OF CORRECTION 7A:
The MHP shall submit a POC that describes how the MHP will ensure that**:**

[229] Line number(s) removed for confidentiality
[230] Line number(s) removed for confidentiality
[231] Line number(s) removed for confidentiality

1) All beneficiaries and their parents/legal guardians are offered oral interpretation services, when applicable.
2) There is documentation substantiating that beneficiaries and their parents/legal guardians are offered mental health interpreter services, when applicable.