CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE PLACER/SIERRA COUNTY MENTAL HEALTH PLAN

CHART REVIEW FINDINGS REPORT

Dates of Review: 2/15/2022 to 2/17/2022

DEPARTMENT OF HEALTH CARE SERVICES
REVIEW OF Placer/Sierra MENTAL HEALTH PLAN
2/16/2022
CHART REVIEW FINDINGS REPORT

Chart Review – Non-Hospital Services

The medical records of ten 10 adult and ten 10 child/adolescent Medi-Cal beneficiaries receiving Specialty Mental Health Services (SMHS) were reviewed for compliance with state and federal regulations; adherence to the terms of the contract between the Placer/Sierra 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 416 claims submitted for the months of January, February and March of **2022**.

Contents

Medical Necessity

FINDING 8.1.2:
The actual interventions documented on the progress notes for the following Line number did not meet medical necessity criteria since the interventions were not reasonably likely to result in at least one of the following: a) significantly diminish the impairment; b) prevent deterioration in an important area of life functioning; c) allow the child to progress developmentally; d) correct or ameliorate the mental health condition of a beneficiary who is under age 21. Specifically:

- **Line number [1].** The interventions documented on two (2) progress notes did not meet the definition of a valid Specialty Mental Health Service. **RR2c, refer to Recoupment Summary for details.**

CORRECTIVE ACTION PLAN 8.1.2:
The MHP shall submit a CAP that describes how the MHP will ensure that all actual SMHS interventions documented on progress notes are reasonably likely to correct or reduce the beneficiary's documented mental health condition, prevent the condition's deterioration, or help a beneficiary who is under age 21 to progress developmentally as individually appropriate.

Assessment

FINDING 8.2.1.:
Assessments were not completed in accordance with regulatory and contractual requirements, specifically:
Two assessments were not completed within the update frequency requirement specified in the MHP's written documentation standards of at least every three (3) years.

Line number [2]. The prior assessment was completed [3], the current assessment was completed 7 days late on [4].

Line number [5]. The prior assessment was completed [6], and the current assessment was completed 20 days late on [7].

CORRECTIVE ACTION PLAN 8.2.1:

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The MHP shall submit a CAP that:

1) Describes how the MHP will ensure that assessments are completed in accordance with the initial timeliness and update frequency requirements specified in the MHP's written documentation standards.
2) Planned Specialty Mental Health Services are not claimed in the absence of an assessment that substantiates those services.

Medication Consent

FINDING 8.3.3:
Ten Medication Consents in the chart sample did not include the signature of the provider of service (or electronic equivalent) that includes the provider's professional degree, licensure, and job title. Specifically:

- **Line numbers [8] *(two consents)*, [9] *(two consents*) and [10].**

CORRECTIVE ACTION PLAN 8.3.3:
The MHP shall submit a CAP that describes how the MHP will ensure that all Medication Consents include the provider's signature (or electronic equivalent) that includes professional degree, licensure or title.

Client Plans

FINDING 8.4.1a:
Services claimed and documented on the beneficiary's progress notes were not sufficient and consistent in amount, duration or scope with those documented on the beneficiary's current Client Plan. Specifically:

- **Line number [11].** Services documented as needed on both Client Plans completed on [12] and [13] include Collateral (2-4 times per month), Medication Support (at least 1 time per quarter), Individual or Group Rehabilitation (2-4 times per month); Targeted Case Management (1-4 times per month) and Individual, Group and/or Family Therapy (2-4 times per month). However, the only services claimed during the three-month chart review period were 10 Medication Support services.

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- **Line number [14].** Services documented as needed on the Client Plan completed on [15] include Collateral (2-4 times per month), Medication Support (at least once per quarter), Individual or Group Rehabilitation (2-4 times per month), and Individual, Group and/or Family Therapy (2-4 times per month). However, the only services claimed during the three-month chart review period were 10 Medication Support services.
- **Line number [16].** Services documented as needed on the Client Plan completed on [17] include Collateral (2-4 times per month), Individual and/or Group Rehabilitation (2-4 times per month), Medication Support (at least once per quarter), Targeted Case Management (1-4 times per month) and Individual, Group and/or Family Therapy (2-4 times per month). However, the only services claimed during the three-month chart review period were one (1) Crisis Intervention service, seven (7) Medication Support services, and two (2) Targeted Case Management services.

CORRECTIVE ACTION PLAN 8.4.1a:
Due to the transition to the new Documentation Standards that will take effect July 1, 2022, a CAP is not required for this item. However, please note that the MHP is expected to continue to ensure compliance with its policies and all current documentation requirements.

FINDING 8.4.2:
Client Plans were not completed prior to the delivery of planned services and/or were not updated at least annually (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards). Specifically:

- **Line number [18].** An Updated Client Plan was not completed until after one or more planned service was provided and claimed. Specifically:
  - The prior Plan, completed on [19] was followed by an updated Plan, completed on [20]. Therefore, no Plan was in effect from [21] until [22]. However, during that time, two Medication Support services were provided on [23]. Review of the chart indicated that these services were not provided on an unplanned or urgent basis.

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The MHP was given the opportunity to locate another Plan that was effective during the service date but was unable to find written evidence of it in the medical record

CORRECTIVE ACTION PLAN 8.4.2:
Due to the transition to the new Documentation Standards that will take effect July 1, 2022, a CAP is not required for this item. However, please note that the MHP is expected to continue to ensure compliance with its policies and all current documentation requirements.

FINDING 8.4.2a:
One or more client plan(s) was not updated at least annually and/or when there were significant changes in the beneficiary's condition. Specifically:

- **Line number [24].** There was a **lapse** between the prior and current Client Plans and, therefore, no client plan was in effect during a portion of the audit review period. See **Finding 8.4.2** above.
- **Line numbers [25].** There was a **lapse** between the prior and current Client Plans. However, this occurred outside of the audit review period.
  - **Line number [26].** Prior Client Plan expired on [27]; current Client Plan completed on [28].
  - **Line number [29].** Prior Client Plan expired on [30]; current Client Plan completed on [31].
  - **Line number [32].** Prior Client Plan expired on [33]; current Client Plan completed on [34].
  - **Line number [35].** Prior Client Plan expired on [36]; current Client Plan completed on [37].

CORRECTIVE ACTION PLAN 8.4.2a:
Due to the transition to the new Documentation Standards that will take effect July 1, 2022, a CAP is not required for this item. However, please note that the MHP is

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expected to continue to ensure compliance with its policies and all current documentation requirements.

FINDING 8.4.11:
One or more Client Plans did not include the provider's signature (or electronic equivalent) that includes their professional degree, licensure or job title. Specifically:

- **Line number [38].** Missing provider's professional degree, licensure, or job title on the Client Plan completed on [39].

CORRECTIVE ACTION PLAN 8.4.11:
Due to the transition to the new Documentation Standards that will take effect July 1, 2022, a CAP is not required for this item. However, please note that the MHP is expected to continue to ensure compliance with its policies and all current documentation requirements.

Progress Notes

FINDING 8.5.1:
Progress notes did not include all required elements specified in the MHP Contract, and/or were not in accordance with the MHP's written documentation standards. Specifically:

- **Line numbers [40].** Fifty-two progress notes, or 12.5 percent of all progress notes reviewed, were not completed within the MHP's written timeliness standard of five business days after provision of services (87.5% compliance).
- **Line number [41].** One progress note did not match its corresponding claim in terms of service date. **RR6, refer to Recoupment Summary for details.**
  - **Line number [42].** The service time documented on one (1) progress note was greater than the Units of Time (UOT) claimed:
    - [43] Claim UOT = 24, Progress Note Total Minutes = 35
- **Line numbers [44]**. The service times documented on a total of 18 progress notes were less than the UOT claimed. However, the dollar amounts claimed did correspond to the service times recorded on their corresponding progress

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notes. The MHP explained that the discrepancy was due to a "system" error since their EHR actually records total service time on the basis of 15-minutes "blocks" or units of time. The system then translates those totals into minutes by dividing them by "15"; the MHP explained further that the system failed to carry out that calculation before submitting those claims to DHCS:

- **Line number [45]:**
  - [46] Claim UOT = 600, Progress Note Total Minutes = 40
  - [47] Claim UOT = 375, Progress Note Total Minutes = 25
  - [48] Claim UOT = 600, Progress Note Total Minutes = 40
  - [49] Claim UOT = 450, Progress Note Total Minutes = 30
  - [50] Claim UOT = 450, Progress Note Total Minutes = 30
  - [51] Claim UOT = 525, Progress Note Total Minutes = 35
  - [52] Claim UOT = 525, Progress Note Total Minutes = 35
  - [53] Claim UOT = 525, Progress Note Total Minutes = 35
  - [54] Claim UOT = 525, Progress Note Total Minutes = 35
  - [55] Claim UOT = 525, Progress Note Total Minutes = 35
  - [56] Claim UOT = 525, Progress Note Total Minutes = 35
- **Line number [57]:**
  - [58] Claim UOT = 720, Progress Note Total Minutes = 48
  - [59] Claim UOT = 540, Progress Note Total Minutes = 36
  - [60] Claim UOT = 615, Progress Note Total Minutes = 41
  - [61] Claim UOT = 600, Progress Note Total Minutes = 40
  - [62] Claim UOT = 600, Progress Note Total Minutes = 40

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- [63] Claim UOT = 375, Progress Note Total Minutes = 25
- [64] Claim UOT = 675, Progress Note Total Minutes = 45

- **Line numbers [65].** Fourteen progress notes contained the exact same intervention verbiage, and therefore those progress notes were not individualized in terms of the specific interventions applied, as specified in the MHP Contract with the Department. Specifically:
  - **Line number [66].** The Intervention recorded on 10 progress notes claimed as Targeted Case Management ([67]) was the exact same verbiage and stated:
    "Writer normalized and validated client's feelings and current state through empathy and reflective listening. Brainstormed with client regarding needs to assist client with symptom stabilization. Linked and connected client with resources in the community to decrease mental health symptoms."
  - **Line number [68].** The Intervention recorded on four (4) progress notes claimed as Mental Health Services, "Individual Psychotherapy" ([69]) was the exact same verbiage and stated:
    "**Current Intervention**: Worked on trying to establish rapport, asked him about things he enjoys. Attempted to assess what challenges he is having."

CORRECTIVE ACTION PLAN 8.5.2:

1) The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document**:**
   - Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.
2) The MHP shall submit a CAP that describes how the MHP will ensure that:
   - Both service dates and times recorded on progress notes match their corresponding claims.
   - Progress notes contain documentation that is individualized for each service provided.
   - Specialty Mental Health Services claimed are accurate and are actually provided to the beneficiary.

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FINDING 8.5.3:
Progress notes were not documented according to the contractual requirements specified in the MHP Contract. Specifically:

- **Line numbers [70].** There was no progress note in the medical record for two (2) service claims. **RR2a, refer to Recoupment Summary for details**.
  The MHP was given the opportunity to locate the documents in question but did not provide written evidence of the documents in the medical record.
- **Line number [71].** For two (2) Mental Health Services claimed, the service activity (e.g., Assessment, Plan Development, Rehab) identified on the progress note was not consistent with the specific service activity actually documented in the body of the progress note:
  - **Line number [72]**. [73] Claimed as TCM; Note Intervention = Rehab
  - **Line number [74]**. [75] Claimed as TCM; Note Intervention = Rehab

CORRECTIVE ACTION PLAN 8.5.3:
The MHP shall submit a CAP that describes how the MHP will:

1) Ensure that all Specialty Mental Health Services 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:
   a) Are accurate, complete and legible and meet the documentation requirements described in the MHP Contract with the Department.
   b) Describe the type of service or service activity, the date of service and the amount of time 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, and as specified in the MHP's written documentation standards.

Provision of ICC Services and IHBS for Children and Youth

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[71] Line number(s) removed for confidentiality
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It is of note that the Placer-Sierra MHP has had an explicit policy regarding the provision of IHBS and ICC services effective since October of 2018. Policy SP 494 states that IHBS and ICC services may be provided for "Full Scope" Medi-Cal beneficiaries who "meet medical necessity criteria" for Specialty Mental Health services, are "In need of intensive mental health services", and that "Involvement in the Child Welfare System and inclusion in the "Katie A" sub-class is not required to receive ICC or IHBS".

The current triennial chart review process includes a search for evidence in the medical record that all Specialty Mental Health beneficiaries have received an individualized determination of whether or not they were eligible and in need of these services.

FINDING 8.6.1:
The medical record associated with the following Line numbers did not contain explicit evidence that the beneficiary received an individualized determination of whether or not they were eligible and in need of IHBS and/or ICC services, and that if appropriate, such services were provided:

- **Line number [76].** While this beneficiary's Client Plan, completed on [77], included ICC services as an intervention stating, "Client will receive ICC services 1-2 times per quarter for 6 months", we were unable to identify any ICC services provided during the chart review period.

- **Line numbers** [78]**.** For these beneficiaries, we were unable to find evidence in the medical record that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS.
  The MHP was given the opportunity to submit any additional evidence of an ICC/IHBS determination "individualized" for each of these beneficiaries. The MHP's written response received is reproduced below. This response was not considered to be evidence of a determination "individualized" for each beneficiary:

  > "Per Policy, ICC and IHBS are provided to youth assessed to be in need of intensive mental health services. To make this determination we're looking at various factors to be ranked as "severe" within our BPS assessments, such as risk, dangerousness, severity of symptoms, crisis encounters, to what extent behaviors are impacting placement instability/stability, CANS scores and historical presentation of symptoms (if a child previously received intensive services, we may consider more intensive services, just because we know there is potential of bigger concerns with the child/family), and scores of 3 in our CANS under behavioral/emotional needs and risk behaviors domains.
  >
  > In addition, we remain in communication with our providers, families and internal partners, so as situations arise, the nature of our integrated system makes it a more effective communication loop to constantly reassess the need for additional services."

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CORRECTIVE ACTION PLAN 8.6.1:

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

1) Written documentation is in place describing the process for determining and documenting eligibility and need for ICC Services and IHBS.
2) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC services and IBHS.
3) Each beneficiary under age 22 who meets medical necessity to receive Specialty Mental Health Services also receives an individualized determination of eligibility and need for IHBS and ICC services that is based on their strengths and needs.
4) The determination is documented in a standard and recognizable manner as part of the medical record.