FISCAL YEAR (FY) 2015/2016 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
BUTTE COUNTY MENTAL HEALTH PLAN REVIEW
January 25, 2016
FINAL FINDINGS REPORT

Section K, "Chart Review – Non-Hospital Services

The medical records of 10 adult and 10 child/adolescent Medi-Cal specialty mental health beneficiaries were reviewed for compliance with state and federal regulations; adherence to the terms of the contract between the BUTTE 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 **_394_** claims submitted for the months of January, February and March of 2015.

Contents

Medical Necessity

PROTOCOL REQUIREMENTS	
1.	Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c. below)?
1a.	The beneficiary has a current ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract?
1b.	The beneficiary, as a result of a mental disorder or emotional disturbance listed in 1a, must have at least one (1) of the following criteria (1-4 below): 1) A significant impairment in an important area of life functioning. 2) A probability of significant deterioration in an important area of life functioning. 3) A probability that the child will not progress developmentally as individually appropriate. 4) For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate.
1c.	Do the proposed and actual intervention(s) meet the intervention criteria listed below: 1) The focus of the proposed and actual intervention(s) is to address the condition identified in No. 1b. (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate per No. 1b(4).
	2) The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or D): A. Significantly diminish the impairment. B. Prevent significant deterioration in an important area of life functioning. C. Allow the child to progress developmentally as individually appropriate. D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.
1d.	The condition would not be responsive to physical health care based treatment.

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

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

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

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

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

RR4. Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:
a) Significantly diminish the impairment;
b) Prevent significant deterioration in an important area of life functioning;
c) Allow the child to progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

FINDING 1c-1:

The medical record associated with the following Line numbers did not meet the medical necessity criteria since the focus of the proposed interventions did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A): [1]**.**
RR3, refer to Recoupment Summary for details

PLAN OF CORRECTION 1c-1:

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

FINDING 1c-2:

The medical record associated with the following Line number did not meet the medical necessity criteria since there was no expectation that the documented intervention would meet the intervention criteria as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4): [2]. **RR4, refer to Recoupment Summary for details**

PLAN OF CORRECTION 1c-2:

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

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

PROTOCOL REQUIREMENTS	
2b.	Do the Assessments include the areas specified in the MHP Contract with the Department? 1) Presenting Problem. The beneficiary's chief complaint, history of presenting problem(s) including current level of functioning, relevant family history and current family information;
	2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;
	3) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports;
	4) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports

[1] *Line number removed for confidentiality*
[2] *Line number removed for confidentiality*

	5) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications;
	6) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs;
	7) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
	8) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
	9) A mental status examination;
	10) A Complete Diagnosis; A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 2b:

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

1) Mental Health History: [3].
2) Medications: [4].
3) Client Strengths: [5].

PLAN OF CORRECTION 2b:

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

PROTOCOL REQUIREMENTS	
2c.	Does the assessment include: 1) The date of service?
	2) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?
	3) The date the documentation was entered in the medical record?
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

[3] *Line number removed for confidentiality*
[4] *Line number removed for confidentiality*
[5] *Line number removed for confidentiality*

FINDING 2c:

The Assessment did not include:

1) Signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title:
    - [6].

PLAN OF CORRECTION 2c:

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

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

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

PROTOCOL REQUIREMENTS		
3.	Regarding medication consent forms:	
3a.	Did the provider obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication?	
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*		• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 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. There was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

- [7]: There was no written medication consent form found in the medical record. *During the review, MHP staff was given the opportunity to locate the missing medication consent form but was unable to locate it in the medical record.*
- [8]: The written medication consent form was not signed by the beneficiary.

PLAN OF CORRECTION 3a:

[6] *Line number removed for confidentiality*
[7] *Line number removed for confidentiality*
[8] *Line number removed for confidentiality*

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

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

PROTOCOL REQUIREMENTS		
3b.	Does the medication consent for psychiatric medications include the following required elements: 1) The reasons for taking such medications?	
	2) Reasonable alternative treatments available, if any?	
	3) Type of medication?	
	4) Range of frequency (of administration)?	
	5) Dosage?	
	6) Method of administration?	
	7) Duration of taking the medication?	
	8) Probable side effects?	
	9) Possible side effects if taken longer than 3 months?	
	10) Consent once given may be withdrawn at any time?	
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*		• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

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 forms found in the beneficiary's medical record:

1) The reason for taking each medication: [9]
2) Reasonable alternative treatments available, if any: [10]
3) Type of medication: [11]
4) Range of frequency: [12]
5) Dosage: [13]
6) Method of administration (oral or injection): [14]

[9] *Line number removed for confidentiality*
[10] *Line number removed for confidentiality*
[11] *Line number removed for confidentiality*
[12] *Line number removed for confidentiality*
[13] *Line number removed for confidentiality*
[14] *Line number removed for confidentiality*

7) Duration of taking each medication: [15]

8) Probable side effects: [16]

9) Possible side effects if taken longer than 3 months: [17]

10) Consent once given may be withdrawn at any time: [18]

PLAN OF CORRECTION 3b:

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

Client Plans

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

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

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

FINDING 4a-2:

The client plan was not updated, at least, annually or when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards):

- [19]: 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. **RR6, refer to Recoupment Summary for details**

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

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

[15] *Line number removed for confidentiality*
[16] *Line number removed for confidentiality*
[17] *Line number removed for confidentiality*
[18] *Line number removed for confidentiality*
[19] *Line number removed for confidentiality*
[20] *Line number removed for confidentiality*

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

PLAN OF CORRECTION 4a-2:

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

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

PROTOCOL REQUIREMENTS		
4b.	Does the client plan include the items specified in the MHP Contract with the Department? 1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.	
	2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.	
	3) The proposed frequency of intervention(s).	
	4) The proposed duration of intervention(s).	
	5) Interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.	
	6) Interventions are consistent with client plan goal(s)/treatment objective(s).	
	7) Be consistent with the qualifying diagnoses.	
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*		• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

FINDING 4b:

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

4b-2) One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan (e.g.

"Medication Support Services," "Targeted Case Management," "Mental Health Services," etc.). [21]

4b-3) One or more of the proposed interventions did not indicate an expected frequency. [22]

4b-7) One or more client plans were not consistent with the qualifying diagnosis. [23]

PLAN OF CORRECTION 4b:

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

1) (4b-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.).
2) (4b-3.) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.
3) (4b-7.) All client plans are consistent with the qualifying diagnosis.

Progress Notes

PROTOCOL REQUIREMENTS		
5a.	Do the progress notes document the following: 1) Timely documentation (as determined by the MHP) of relevant aspects of client care, including documentation of medical necessity?	
	2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions?	
	3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions?	
	4) The date the services were provided?	
	2) Documentation of referrals to community resources and other agencies, when appropriate?	
	3) Documentation of follow-up care or, as appropriate, a discharge summary?	
	4) The amount of time taken to provide services?	
	5) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?	
• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*		• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

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

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

[21] *Line number removed for confidentiality*
[22] *Line number removed for confidentiality*
[23] *Line number removed for confidentiality*

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

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

RR4. Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:
a) Significantly diminish the impairment;
b) Prevent significant deterioration in an important area of life functioning;
c) Allow the child to progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

RR9. No progress note was found for service claimed.

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

RR13 The progress note indicates that the service provided was solely for one of the following:

a) Academic educational service;
b) Vocational service that has work or work training as its actual purpose;
c) Recreation; or
d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.

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

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

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

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

RR19a. No service was provided.

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

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

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

FINDING 5a:

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

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

5a-1) [24]**:** Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period).

5a-4) [25]**:** 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.

- Appointment was missed or cancelled: [26]**.**
  RR19a, refer to Recoupment Summary for details.

PLAN OF CORRECTION:

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

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

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

   5a-4) The date the progress note was completed and entered into the medical record by the person(s) providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.
4) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning.

FINDING 5a3:

The progress note for the following Line number indicates that the service provided was solely:

- **Clerical: [27]. RR17, refer to Recoupment Summary for details.**

PLAN OF CORRECTION:

[24] *Line number removed for confidentiality*
[25] *Line number removed for confidentiality*
[26] *Line number removed for confidentiality*
[27] *Line number removed for confidentiality*

The MHPshall submit a POC that indicates how the MHP will ensure that services provided and claimed are not solely clerical.

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

FINDING 5c:

Documentation in the medical record did not meeting the following requirements:

- [28]: There was no progress note in the medical record for the services claimed. **RR9, refer to Recoupment Summary for details.**

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

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

PLAN OF CORRECTION 5c:

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

1) Ensure that all specialty mental health services (SMHS) claimed are:
   a. Documented in the medical record.
   b. Actually provided to the beneficiary.

[28] *Line number removed for confidentiality*
[29] *Line number removed for confidentiality*

c. 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).

d. Claimed for the correct service modality and billing code.

2) Ensure that all progress notes are:

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

b) Indicate the type of service, the date the service was provided and the amount of time taken to provide the service as specified in the MHP Contract with the Department.

c) Completed within the timeline and frequency specified in the MHP Contract with the Department.

PROTOCOL REQUIREMENTS		
5d.	Do all entries in the beneficiary's medical record include: 1) The date of service?	
	2) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?	
	3) The date the documentation was entered in the medical record?	
• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*		• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

FINDING 5d:

The Progress notes did not include:

- Date of service: [30]
- Date the documentation was entered into the medical record: [31]

PLAN OF CORRECTION 5d:

The MHP shall submit a POC that indicates how the MHP will ensure that all documentation includes the date the signature was completed and the document was entered into the medical record.

Service Components for Day Treatment Intensive and Day Rehabilitation Programs

[30] *Line number removed for confidentiality*
[31] *Line number removed for confidentiality*

PROTOCOL REQUIREMENTS	
7b.	Regarding Attendance: 1) Is there documentation of the total number of minutes/hours the beneficiary actually attended the program?
	2) If the beneficiary is unavoidably absent: A. Is the total time (number of hours and minutes) the beneficiary actually attended the program that day documented; B. Is the beneficiary present for at least 50 percent of the scheduled hours of operation for that day; **AND**, C. Is there a separate entry in the medical record documenting the reason for the unavoidable absence?
• *CCR, title 9, chapter 11, section 1810.212* • *CCR, title 9, chapter 11, section 1810.213* • *CCR, title 9, chapter 11, section 1840.112(b)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 11, section 1840.318* • *CCR, title 9, chapter 11, section 1840.360* • *MHP Contract, Exhibit A, Attachment I* • *DMH Letter No. 03-03*

FINDING 7b:

Documentation for the following Line number indicated that essential requirements for a Day Rehabilitation program were not met, as specified by the MHP Contract with the Department:

- [32]: Day Rehabilitation services claimed when the beneficiary was absent or was not present for the minimum amount of time to be claimed. The MHP should review all beneficiaries' past services and claims for this provider ([33]) to determine if billing was appropriate and disallow those claims that were not correctly billed. **RR10, refer to Recoupment Summary for details.**

PLAN OF CORRECTION:

1) Ensure that the total number of minutes/hours each beneficiary actually attends a *Day Rehabilitation* program is documented.
2) Ensure that all *Day Rehabilitation* services claimed were actually provided to the beneficiary as specified in the MHP Contract.

PROTOCOL REQUIREMENTS	
7c.	Regarding Continuous Hours of Operation: Did the provider apply the following when claiming for the continuous hours of operation of *Day Treatment Intensive* and *Day Rehabilitation* services? A. For Half Day: The beneficiary received face-to-face services a minimum of three (3) hours each day the program was open. B. For Full-Day: The beneficiary received face-to-face services in a program with services available more than four (4) hours per day.
• *CCR, title 9, chapter 11, section 1810.212* • *CCR, title 9, chapter 11, section 1810.213* • *CCR, title 9, chapter 11, section 1840.112(b)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 11, section 1840.318* • *CCR, title 9, chapter 11, section 1840.360* • *MHP Contract, Exhibit A, Attachment I* • *DMH Letter No. 03-03*

[32] *Line number removed for confidentiality*
[33] *Provider number removed for confidentiality*

FINDING 7c:

Documentation for the following Line number indicated that essential requirements for a Day Rehabilitation program were not met, as specified by the MHP Contract with the Department:

- [34]**:** The beneficiary did not receive the minimum required hours in order to claim for full day of *Day Rehabilitation*. **RR10, refer to Recoupment Summary for details.**

PLAN OF CORRECTION:

The MHP shall submit a POC that indicates how the MHP will ensure the provider provides the required hours each day when claiming for the continuous hours of operation of *Day Treatment Intensive*/*Day Rehabilitation*

[34] *Line number removed for confidentiality*