Section B, Access, Questions 9a2 and 9a3

9a. Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:

2) Does the toll-free telephone number provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met?

3) Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?

CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1)

1 *CFR, title 42, section 438.406 (a)(1)*

DMH Information Notice No. 10-02, Enclosure, Page 21, and DMH Information Notice No. 10-17, Enclosure, Page 16

MHP Contract, Exhibit A, Attachment 1

The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a statewide, toll-free telephone number 24 hours a day, 7 days per week, with language capability in all languages spoken by beneficiaries of the county that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

The County entered into a contract with Heritage Oaks Hospital to operate the County's 24/7 toll-free Access Line (implementation date July 1, 2018). The County also updated the Access Log in Avatar (implementation date July 1, 2018), which is the mechanism used to help track and monitor contacts made through the 24/7 toll-free Access Line by or on behalf of the beneficiary. The new Access Log is designed to capture all regulatory requirements, including date / time / name of person making contact and beneficiary, type of contact (walk-in, call-in via Access Line or other, written), reason for contact (e.g., crisis, urgent condition, beneficiary protection, service request for mental health / substance use / co-occurring), beneficiary's primary / preferred language, whether the contact was provided in the beneficiary's primary language, whether an interpreter or Language Line assistance was used, and contact disposition.

On June 28, 2018, the County conducted training with Access point staff (including Heritage Oaks) on the new Access Log and the Access Log Desk Reference (Attachment 1A). This training included guidance on how to provide information to beneficiaries about (a) how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and (b) services needed to treat a beneficiary's urgent condition. Next steps will include ongoing monitoring and training to ensure compliance.

The County also implements Access Line Test Call Policy and Procedure #5-10-004 (Attachment 1B) to monitor the responsiveness and effectiveness of the Access Line and identify potential areas for quality improvement (QI) efforts, including but not limited to:

- Availability (24 hours a day, seven days a week)
- Helpfulness and knowledge of staff, including ability to provide information on how to access SMHS and services to address a beneficiary's urgent condition, how to use the beneficiary problem resolution and fair hearing processes, and how to access the MHP's provider directory
- Ability to respond to the callers in their primary language
- Compliance with state documentation guidelines for logging requests for services

The Quality Management (QM) Unit will maintain the Access Test Call Log (Attachment 1C) for quarterly state reporting and QI purposes. Access Line test call results will also be discussed at the Quality Improvement Committee (QIC) to obtain stakeholder input and feedback to inform further improvement efforts as needed.

Status: Completed

MHP Responsible Party: Katherine Barrett

Target Completion Date: July 1, 2018

	<u>Section B, Access, Questions 10b1, 10b2, and 10b3</u> **10. Regarding the written log of initial requests for SMHS:** **b. Does the written log(s) contain the following required elements:** **1) Name of the beneficiary?** **2) Date of the request?** **3) Initial disposition of the request?** *CCR, title 9, chapter 11, section 1810.405(f)*	The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person, or in writing) complies with all regulatory requirements.	The County implements Access Log Policy and Procedure #5-10-003 (Attachment 2A) to ensure that all initial requests for services are documented in the Access Log in compliance with regulatory requirements. With the implementation of the new Access Log and 24/7 Access Line contract on July 1, 2018, the County has streamlined the access process so that all initial requests for SMHS – whether made during business hours or after hours, in person, via phone, or in writing – are captured in the newly updated Access Log in Avatar. The new Access Log was designed to more reliably track and monitor requests for SMHS as well as capture all other regulatory requirements, including date / time / name of person making contact and beneficiary, type of contact (walk-in, call-in via Access Line or other, written), reason for contact (e.g., crisis, urgent condition, beneficiary protection, service request for mental health / substance use / co-occurring), beneficiary's primary / preferred language, whether the contact was provided in the beneficiary's primary language, whether an interpreter or Language Line assistance was used, and contact disposition. To ensure that the log of initial requests for SMHS contains the required elements (i.e., name of beneficiary, date of request, initial disposition), the new Access Log was designed to make entry into these fields a requirement. Further, the Access Log is required to be used at all access points for SMHS. As part of the implementation process, a training was provided on June 28, 2018 to Access point staff who utilize the Access Log. Next steps will include ongoing monitoring and training to ensure all initial requests for SMHS are being appropriately logged. Please refer to the following as evidence: • Access Log tracking spreadsheet that aligns with the Access Log data fields in Avatar (required POC fields highlighted in **yellow**) – (Attachment 2B) • Access Log Desk Reference – (Attachment 1A) <u>Status</u>: Completed <u>MHP Responsible Party</u>: Katherine Barrett <u>Target Completion Date</u>: July 1, 2018
2			

3	**Section C, Authorization, Question 2c** **2. Regarding Standard Authorizations Requests for non-hospital SMHS:** **c) For standard authorization decisions, does the MHP make an authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days?** *CFR, title 42, section 438.210(b)(3)* *CFR, title 42, section 438.210(d)(1),(2)* *CCR, title 9, chapter 11, sections 1810.253, 1830.220, 1810.365, and 1830.215 (a-g)*	[DHCS provided a duplicate statement that applies to question E1 below]	The County currently implements Policy and Procedure #5-7-003 Internal Authorizations and Re-Authorizations for SMHS (Attachment 3A) to ensure standard authorization decisions and notices for non-hospital SMHS are provided expeditiously in accordance with regulatory requirements. The County was found to be out of compliance with one (1) of twenty-five (25) Standard Authorization Requests (SARS) due to a missing date stamp on a provider's response to the County's request for corrections. While date / time stamping is currently a part of the SAR process, the County plans to add an addendum to this Policy and Procedure (#5-7-003) to formalize this process and provide training to the appropriate staff. Status: In Progress MHP Responsible Party: Katherine Barrett Target Completion Date: September 30, 2018
4	**Section E, Funding, Reporting & Contracting Requirements, Question 1** **1. Did the MHP comply with the requirements of W&I Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports?** *Welfare and Institutions Code Sections 14705(c) and 14712(e)* *MHSUDS IN No. 17-025*	The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with timely submission of its annual cost report.	Yolo County Health and Human Services Agency (HHSA) has experienced difficulty in becoming current with State reporting since the redesign of the accounting system in 2015. HHSA has identified several barriers, including insufficient staffing levels and General Ledger account structure, and is addressing those barriers at this time. HHSA dedicated two staff to allocate Mental Health costs, reconcile the County General Ledger and to complete all outstanding Cost Reports. As of June 30,2018, all Mental Health Cost Reports for Yolo County have been submitted Status: In Progress MHP Responsible Party: Connie Cessna-Smith Target Completion Date: July 1, 2018

5	**Section G, Provider Relations, Questions 2a and 2b** **2. Regarding the MHP's ongoing monitoring of county-owned and operated and contracted organizational providers:** **a) Does the MHP have an ongoing monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified as per title 9 regulations?** **b) Is there evidence the MHP's monitoring system is effective?** *CCR, title 9, chapter 11, section 1810.435 (d)I* *MHP Contract, Exhibit A, Attachment 1*	The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has an ongoing and effective monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified per title 9 regulations.	The County implements Policy and Procedure #5-5-003 Medi-Cal Site Certification to manage a monitoring system to ensure contracted providers and county-owned and operated providers are certified and recertified per Title 9 regulations (Attachment 5A). The County has developed a database to monitor provider certification and recertifications to enable the Quality Management Analyst to pull reports on recertification requirements by dates which are completed on a monthly basis. Any new certifications are completed and entered into the database to ensure tracking and monitoring. The county shall conduct monthly reviews of all providers, to include county-owned and operated, to ensure that all providers are certified and recertified per Title 9 regulations. Status: In Progress MHP Responsible Party: Katherine Barrett Target Completion Date: September 30, 2018

FISCAL YEAR (FY) 2017/2018 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
SACRAMENTO COUNTY MENTAL HEALTH PLAN REVIEW
April 16, 2018
FINDINGS REPORT

Section K, "Chart Review – Non-Hospital Services

The medical records of ten (10) adult and ten (10) child/adolescent Medi-Cal specialty mental health beneficiaries were reviewed for compliance with state and federal regulations; adherence to the terms of the contract between the Sacramento 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 **_477_** claims submitted for the months of **July**, **August**, and **September** of 2017.

Contents

Medical Necessity

PROTOCOL REQUIREMENTS	
1. 1a.	Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c. below)? 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*

<u>Reasons for Recoupment (RR)</u>: *Refer to the enclosed Recoupment Summary for additional details concerning disallowances.*

RR3. Documentation in the medical record does not establish the expectation that the claimed intervention(s) 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;
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

RR13. No service provided:
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 definition of a specific SMHS,

FINDING 1c-1:
The medical record associated with the following Line number(s) did not meet medical necessity criteria since the focus of the proposed and actual intervention(s) did not address the mental health condition, as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A):

- **Line number(s) [1]. RR13b refer to Recoupment Summary for details.**

PLAN OF CORRECTION 1c-1:
The MHP shall submit a POC that describes how the MHP will ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition, as specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

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

- **Line number(s) [2]. RR3a, refer to Recoupment Summary for details.**

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

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

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

PROTOCOL REQUIREMENTS		
2.	Regarding the Assessment, are the following conditions met: 1) Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness?	
2a.	2) Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency?	
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*		• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDINGS 2a:

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

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:

- **Line number(s) [3]**: The initial assessment was completed late.
- **Line number(s) [4]**: The updated assessment was completed late.

PLAN OF CORRECTION 2a:

The MHP shall submit a POC that describes how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

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;

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

	2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors;
	3) History of trauma or exposure to trauma;
	4) 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;
	5) 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
	6) 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;
	7) 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;
	8) 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;
	9) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
	10) A mental status examination;
	11) A Complete Diagnosis; A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851-Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 2b:

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

1) Medications: **Line number(s) [5].**
2) Substance Exposure/Substance Use: **Line number [6].**

PLAN OF CORRECTION 2b: The MHP shall submit a POC that describes how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department.

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*

FINDING 2c:
The Assessment(s) did not include:

Signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title:

- **Line number(s) [7].**

PLAN OF CORRECTION 2c:
The MHP shall submit a POC that describes 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 signature of the qualified person (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

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

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

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 form, and/or documented to have been reviewed with the beneficiary, and/or provided in accompanying written materials to the beneficiary:

4) Range of Frequency: **Line number [8].**

5) Dosage: **Line number [9].**

6) Method of administration (oral or injection): **Line number(s) [10].**

7) Duration of taking each medication: **Line number(s) [11].**

9) Possible side effects if taken longer than 3 months: **Line number(s) [12].**

PLAN OF CORRECTION 3b:

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

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

PROTOCOL REQUIREMENTS		
3c.	Do medication consents 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*

FINDING 3c:
The medication consent(s) did not include:

Signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title:

- **Line number(s) [13].**

PLAN OF CORRECTION 3c:
The MHP shall submit a POC that describes how the MHP will ensure that all documentation includes the signature (or electronic equivalent) of the qualified person providing the service with the professional degree, licensure or title.

Client Plans

PROTOCOL REQUIREMENTS	
4.	Regarding the client plan, are the following conditions met:
4a.	Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?

[13] Line number(s) removed for confidentiality

• *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*

RR5. Services that cannot be claimed without a Client Plan in place were claimed either:
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 there was no client plan in effect.

FINDING 4a:
The Client Plan was not completed prior to planned services being provided and not updated at least annually or reviewed and updated when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards):

- **Line number [14]**: 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. **RR5b, refer to Recoupment Summary for details.**
- **Line number(s) [15]**: There was a **lapse** between the prior and current client plans. However, this occurred outside of the audit review period.
- **Line number(s) [16]**: There was a **lapse** between the prior and current client plans. However, no services were claimed.
- **Line number(s) [17]**: 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 in question on a client plan but could not find written evidence of it. **RR5c, refer to Recoupment Summary for details**

PLAN OF CORRECTION 4a:

[14] Line number(s) removed for confidentiality
[15] Line number(s) removed for confidentiality
[16] Line number(s) removed for confidentiality
[17] Line number(s) removed for confidentiality

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

1) Ensure that client plans are completed prior to planned services being provided.

2) Ensure that planned services are not claimed when the service provided is not included in the current client plan.

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 number(s) had client plan(s) that did not include all of the items specified in the MHP Contract with the Department:

4b-1) 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 number(s) [18].**

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

[18] Line number(s) removed for confidentiality

plan (e.g. "Medication Support Services," "Targeted Case Management," "Mental Health Services," etc.). **Line number(s) [19].**

4b-3) One or more of the proposed interventions did not indicate an expected frequency. **Line number(s) [20].**

4b-4) One or more of the proposed interventions did not indicate an expected duration. **Line number(s) [21].**

PLAN OF CORRECTION 4b:

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

1) (4b-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) (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.).
3) (4b-3, 4b-4.) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

PROTOCOL REQUIREMENTS		
4e.	Is there documentation that the provider offered a copy of the client plan to the beneficiary?	
• *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 4e:

There was no documentation that the beneficiary or legal guardian was offered a copy of the client plan (at the time of completion) for the following:

[19] Line number(s) removed for confidentiality
[20] Line number(s) removed for confidentiality
[21] Line number(s) removed for confidentiality

- **Line number(s) [22].** The notes addressing offering a copy of the client plan to the beneficiary were documented after the sample was faxed to the MHP on [23].

PLAN OF CORRECTION 4e:

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.

Progress Notes

PROTOCOL REQUIREMENTS		
5a.	Do the progress notes document the following: 1) Timely documentation 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*

RR6. No progress note found for service claimed.

[22] Line number(s) removed for confidentiality
[23] Date(s) removed for confidentiality

a) No progress note found.
b) Progress note provided does not match the claim in terms of
   1) Specialty Mental Health Service and/or Service Activity claimed.
   2) Date of Service, and/or
   3) Units of time.

RR13. No service was provided:

a) No show/appointment cancelled, and no other eligible service documented
b) Service provided did not meet definition of a specific SMHS.

FINDING 5a:

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

- One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements.
- Progress notes did not document the following**:**

5a-1) Line number(s) [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-7i) Line number [25]: The amount of time taken to provide services. There was a progress note in the medical record for the date of service claimed. However, the amount of time documented on the progress note to provide the service was less than the time claimed. **RR6b3, refer to Recoupment Summary for details.**

- **Line number [26]**: Appointment was missed or cancelled. **RR13a, refer to Recoupment Summary for details.**

PLEASE NOTE: The exact same verbiage was recorded on multiple progress notes, and therefore those progress notes were not individualized, did not accurately document the beneficiary's response and the specific interventions applied, as specified in the MHP Contract with the Department for: **Line number [27].**

- Line number [28]: Two progress notes dated [29] with exact verbiage.

PLAN OF CORRECTION 5a:

[24] Line number(s) removed for confidentiality
[25] Line number(s) removed for confidentiality
[26] Line number(s) removed for confidentiality
[27] Line number(s) removed for confidentiality
[28] Line number(s) removed for confidentiality
[29] Date(s) removed for confidentiality

The MHP shall submit a POC that describes how the MHP will ensure that the MHP has written documentation standards for progress notes, including timeliness and frequency, as required by the MHP Contract with the Department.

1) The MHP shall submit a POC that describes how the MHP will ensure that progress notes document**:**

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

   5a-7) The accurate amount of time taken to provide services.

2) Documentation is individualized for each service provided.

<table>
<tr><th colspan="3">PROTOCOL REQUIREMENTS</th></tr>
<tr><td>5b.</td><td colspan="2">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?</td></tr>
<tr><td></td><td colspan="2">2) The exact number of minutes used by persons providing the service?</td></tr>
<tr><td></td><td colspan="2">3) Signature(s) of person(s) providing the services?</td></tr>
<tr><td colspan="2">• 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</td><td>• 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</td></tr>
</table>

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

RR11. Progress notes for group activities involving two (2) or more providers did not clearly document the following:

a) The specific involvement of each provider in the context of the mental health needs of the beneficiary;
b) The specific amount of time of involvement of each group provider in providing the service, including travel and documentation time if applicable; and
c) The total number of group participants

FINDING 5b:

Documentation of services being provided to, or on behalf of, a beneficiary by two or more persons at one point in time did not include all required components. Specifically:

- **Line number(s) [30]**: Progress notes did not document the specific involvement of each provider in the context of the mental health needs of the beneficiary. **RR11a, refer to Recoupment Summary for details.**
- **Line number [31]**: Progress notes did not document the specific amount of time of involvement of each provider, including travel and documentation time, if appropriate. **RR11b, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5b:

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

1) All group progress notes document the number of clients in the group, number of staff, units of time, type of service and dates of service (DOS).
2) 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.

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 E. Intensive Care Coordination F. Intensive Home Based Services G. Therapeutic Behavioral Services a. Daily for: A. Crisis residential B. Crisis stabilization (one per 23/hour period) C. Day treatment intensive D. Therapeutic Foster Care b. Weekly for: A. Day treatment intensive (clinical summary) B. Day rehabilitation C. Adult residential

[30] Line number(s) removed for confidentiality
[31] Line number(s) removed for confidentiality

• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*	• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

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

RR6. No progress note found for service claimed.
- c) No progress note found.
- d) Progress note provided does not match the claim in terms of
  - 4) Specialty Mental Health Service and/or Service Activity claimed.
  - 5) Date of Service, and/or
  - 6) Units of time.

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

1. **Line number [32]**: There was no progress note in the medical record for the service(s) claimed. **RR6a, 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.

2. a. **Line number(s) [33]**: The type of specialty mental health service (SMHS) (e.g., Medication Support, Targeted Case Management) documented on the progress note was not the same type of SMHS claimed. **Refer to RR6b-1 exception letter for details.**

   b. **Line numbers [34]**: For 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 [35]:** Progress notes dated [36] identified the service activity as Rehabilitation but the documentation referred to Assessment or Collateral.

[32] Line number(s) removed for confidentiality
[33] Line number(s) removed for confidentiality
[34] Line number(s) removed for confidentiality
[35] Line number(s) removed for confidentiality
[36] Date(s) removed for confidentiality

- **Line number [37]:** Progress note dated [38] identified the service activity as Collateral but the documentation referred to Assessment or Plan Development.
- **Line number [39]:** Progress note dated [40] identified the service activity as Assessment but the documentation referred to Plan Development.

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

1) Ensure that all SMHS claimed are:
   a) Documented in the medical record.
   b) Claimed for the correct service modality billing code, and units of time.
2) Ensure that all progress notes:
   a) 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.
   b) Are 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*

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

[37] Line number(s) removed for confidentiality
[38] Date(s) removed for confidentiality
[39] Line number(s) removed for confidentiality
[40] Date(s) removed for confidentiality

RR14. The service provided was not within the scope of practice of the person delivering the service.

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

- Signature of a provider whose scope of practice includes the provision of the service documented on the progress note; i.e., the provider's scope of practice did not include completing an assessment without a co-signature by an LPHA:
  Line number [41]. RR14, refer to Recoupment Summary for details.

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

1) All documentation includes the signature or (electronic equivalent) with the professional degree, licensure or title of the person providing the service.
2) 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.
3) Staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.
4) Services are not claimed when they are provided by staff whose scope of practice or qualifications do not include those services.
5) All claims for services delivered by any person who was not qualified to provide are disallowed.

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

RR9. 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.
e) Transportation
f) Clerical
g) Payee Related

[41] Line number(s) removed for confidentiality

FINDING 5e:
The progress note for the following Line number indicate that the service provided was solely**:**

- Clerical: **Line number [42]. RR9f, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5e:
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 transportation, clerical or payee related.
3) 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).

[42] Line number(s) removed for confidentiality