DEPARTMENT OF HEALTH CARE SERVICES
REVIEW OF MADERA MENTAL HEALTH PLAN
December 5 – 6, 2018
CHART REVIEW FINDINGS REPORT

Chart Review – Non-Hospital Services

The medical records of five (**5**) adult and five (**5**) child/adolescent Medi-Cal specialty mental health beneficiaries were reviewed for compliance with state and federal regulations; adherence to the terms of the contract between the Madera 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 **170** claims submitted for the months of **January, February, and March of 2018**.

Contents

Medical Necessity

REQUIREMENTS
The MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary. a) No show / appointment cancelled, and no other eligible service documented (e.g., chart review to prepare for an appointment that turns out to be a "no show'), or b) Service provided did not meet the applicable definition of a SMHS. (MHSUDS IN No. 17-050, Enclosure 4)

FINDINGS

The MHP submitted claims for reimbursement for services rendered but was unable to demonstrate that it furnished a valid service to, or on behalf of, the beneficiary.

- **Line numbers [1].** Please refer to Recoupment Summary, reason for recoupment (RR) #15, for additional details.

PLAN OF CORRECTION

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).

Assessment

REQUIREMENTS
The MHP shall ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed: a) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information; b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma; c) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports; d) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical

[1] Line number(s) removed for confidentiality

treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;

e) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;

f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;

g) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;

h) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;

i) A mental status examination;

j) A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,

k) Additional clarifying formulation information, as needed.

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

FINDINGS

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

- The type of professional degree, licensure, or job title of person providing the service:
  - **Line numbers [2].**

PLAN OF CORRECTION

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

Medication Consent

[2] Line number(s) removed for confidentiality

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

FINDING 3A:

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

1) **Line numbers [3]**: There was no written medication consent form found in the medical record. *The MHP did not submit all required medication consent documentation.*
2) **Line number [4]**: The written medication consent form was not signed by the beneficiary.
3) **Line numbers [5]**: Although there was a written medication consent form in the medical record, there was no medication consent for each of the medications prescribed. *The MHP did not submit all required medication consent documentation.*

PLAN OF CORRECTION 3A:

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

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

REQUIREMENTS

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

Medication consent for psychiatric medications shall include the following required elements:

1) The reasons for taking such medications.
2) Reasonable alternative treatments available, if any.
3) Type of medication.
4) Range of frequency (of administration).
5) Dosage.
6) Method of administration.
7) Duration of taking the medication.
8) Probable side effects.
9) Possible side effects if taken longer than 3 months.
10) Consent once given may be withdrawn at any time.

(MHP Contract, Ex. A, Attachment 9)

FINDING 3B:
Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented on the medication consent form, and/or documented to have been reviewed with the beneficiary, and/or provided in accompanying written materials to the beneficiary:

1) Reasonable alternative treatments available, if any: **Line numbers [6].**

2) Type of medication: **Line number [7].**

3) Range of Frequency: **Line numbers [8].**

4) Dosage: **Line numbers [9].**

5) Method of administration (oral or injection): **Line numbers [10].**

6) Duration of taking each medication: **Line numbers [11].**

7) Possible side effects if taken longer than 3 months: **Line numbers [12].**

10) Consent once given may be withdrawn at any time: **Line numbers [13].**

PLAN OF CORRECTION 3B:
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.

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

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

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

- The type of professional degree, licensure, or job title of person providing the service:
  - **Line numbers [14].**

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

Client Plans

REQUIREMENTS
Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. Services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary. (MHP Contract, Ex. A, Attachment 2)
The client plan shall be updated at least annually, or when there are significant changes in the beneficiary's condition. (MHP Contract, Ex. A, Attachment 9)

[14] Line number(s) removed for confidentiality

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

RR4. Services shall be provided, in accordance with the State Plan, based on the beneficiary's need for services established by an Assessment and documented in the Client Plan. Services were claimed:
a) Prior to the initial Client Plan being in place; or
b) During the period where there was a gap or lapse between client plans; or
c) When the planned service intervention was not on the current client plan.

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

FINDING 4B:
Client Plans were not completed prior to the delivery of planned services and/or were not updated at least annually or reviewed and updated when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards). Below are the specific findings pertaining to the charts in the review sample:

- **Line number [15]:** The initial client plan was not completed until after treatment services were claimed. **RR4a, refer to Recoupment Summary for details.**
- The medical record indicated an acute change in the beneficiary's mental health status (e.g. hospitalized, suicide attempt, multiple crisis intervention encounters.
    - **Line number [16]:** The beneficiary experienced multiple crisis admissions following the initial assessment and client plan.
    - **Line number [17]:** The beneficiary was admitted to an inpatient hospital on [18] for suicidal ideation with a plan to overdose.

  However, no evidence was found in the either beneficiary's medical records that their client plans were reviewed and/or updated in response to the changes.

PLAN OF CORRECTION 4A:
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 client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

REQUIREMENTS

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

The MHP shall ensure that Client Plans:

a) Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.
b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.
c) Have a proposed frequency of intervention(s).
d) Have a proposed duration of intervention(s).
e) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b).
f) Have interventions that are consistent with the client plan goals.
g) Be consistent with the qualifying diagnoses.

(MHP Contract, Ex. A, Attachment 9)

FINDING 4C:

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

- One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis. **Line numbers [19].**
- One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan. **Line numbers [20].**
- One or more of the proposed interventions did not indicate an expected frequency. **Line numbers [21].**
- One or more of the proposed interventions did not indicate an expected duration. **Line numbers [22].**
- One or more of the proposed interventions did not address the mental health needs and functional impairments identified as a result of the mental disorder. **Line number [23].**
- One or more of the proposed interventions were not consistent with client plan goals/treatment objectives. **Line number [24].**
- One or more client plans were not consistent with the qualifying diagnosis. **Line number [25].**

[19] Line number(s) removed for confidentiality
[20] Line number(s) removed for confidentiality
[21] Line number(s) removed for confidentiality
[22] Line number(s) removed for confidentiality
[23] Line number(s) removed for confidentiality
[24] Line number(s) removed for confidentiality
[25] Line number(s) removed for confidentiality

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

1) All client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.
2) All mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).
3) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.
4) All mental health interventions/modalities proposed on client plans address the mental health needs and identified functional impairments of the beneficiary as a result of the mental disorder.
5) All mental health interventions proposed on client plans are consistent with client plan goals/treatment objectives.
6) All client plans are consistent with the qualifying diagnosis.

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

FINDING 4G:
There was no documentation that the beneficiary or legal guardian was offered a copy of the client plan for the following: **Line number [26].**

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

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

REQUIREMENTS
All entries in the beneficiary record (i.e., Client Plans) include: 1) Date of service. 2) The signature of the person providing the service (or electronic equivalent); 3) The person's type of professional degree, licensure or job title.

[26] Line number(s) removed for confidentiality

4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

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

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

The type of professional degree, licensure, or job title of person providing the service

- **Line number [27].**

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

Progress Notes

REQUIREMENTS

[27] Line number(s) removed for confidentiality

The MHP shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan.

Items that shall be contained in the client record related to the beneficiary's progress in treatment include:

a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;

b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;

d) The date the services were provided;

e) Documentation of referrals to community resources and other agencies, when appropriate;

f) Documentation of follow-up care, or as appropriate, a discharge summary; and

g) The amount of time taken to provide services; and

h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.

(MHP Contract, Ex. A, Attachment 9)

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

RR7. The progress note does not describe how services provided to the beneficiary reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.

RR15. The MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:

a) No show / appointment cancelled, and no other eligible service documented (e.g., chart review to prepare for an appointment that turns out to be a "no show"), or
b) Service provided did not meet the applicable definition of a SMHS.

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

FINDING 5A:
The progress note does not describe how services provided to the beneficiary reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.
Line numbers [28]. RR7, refer to Recoupment Summary for details.

PLAN OF CORRECTION 5A:
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 5B:
Progress notes did not include timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity, as required in the MHP Contract. One or more progress notes was not completed within the timeliness and/or frequency standards in accordance with the MHP Contract and the MHP's written documentation standards. Below are the specific findings pertaining to the charts in the review sample:

- Progress notes associated with the following line numbers did not include timely documentation of relevant aspects of beneficiary care, as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period). **Line numbers [29].**
- Appointment was missed or cancelled. **Line number [30]. RR15a, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5B:
1) 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.
2) The MHP shall submit a POC that describes how the MHP will ensure that progress notes document**:**
    - Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.
3) Specialty Mental Health Services claimed are actually provided to the beneficiary.

[28] Line number(s) removed for confidentiality
[29] Line number(s) removed for confidentiality
[30] Line number(s) removed for confidentiality

REQUIREMENTS
When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include: 1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary. 2) The exact number of minutes used by persons providing the service. 3) Signature(s) of person(s) providing the services. (CCR, title 9, § 1840.314(c).)
Reasons for Recoupment (RR): *Refer to the enclosed Recoupment Summary for additional details about disallowances.* RR13. For service activities involving one (1) or more providers, progress notes, or other relevant documentation in the medical record, did not clearly include the following: a) The total number of providers and their specific involvement in the context of the mental health needs of the beneficiary; **or** b) The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable; ***or*** c) The total number of beneficiaries participating in the service activity. (MHSUDS IN No. 17-050, Enclosure 4)

FINDING 5C:

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

- **Line numbers [31]**: Progress notes did not document the specific involvement of each provider in the context of the mental health needs of the beneficiary. **RR13a, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5C:

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

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

REQUIREMENTS
Progress notes shall be documented at the frequency by type of service indicated below:

[31] Line number(s) removed for confidentiality

a) Every Service Contact:
   i. Mental Health Services;
   ii. Medication Support Services;
   iii. Crisis Intervention;
   iv. Targeted Case Management;

b) Daily:
   i. Crisis Residential;
   ii. Crisis Stabilization (1x/23hr);
   iii. Day Treatment Intensive;

c) Weekly:
   i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;
   ii. Day Rehabilitation;
   iii. Adult Residential.

(MHP Contract, Ex. A, Attachment 9)

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

RR8. The MHP did not submit a progress note corresponding to the claim submitted to DHCS for reimbursement, as follows:

a) No progress note submitted

b) The progress note provided by the MHP does not match the claim submitted to DHCS for reimbursement in terms of the following:
   1) Specialty Mental Health Service claimed.
   2) Date of service, and/or
   3) Units of time.

RR20. Required DTI/DR documentation was not present as follows:

a) There was not a clinical summary present for Day Treatment Intensive Services for the week of the service reviewed
b) There was not a daily progress note present for Day Treatment Intensive Services for the day of the service reviewed
c) There was not a weekly progress note present for Day Rehabilitation Services for the week of the service reviewed.

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

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

- **Line numbers [32]**: 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. **RR8b1, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5D:
The MHP shall submit a POC that describes how the MHP will ensure that all SMHS claimed are claimed for the correct service modality billing code, and units of time.

REQUIREMENTS
All entries in the beneficiary record (i.e., Progress Notes) include: 1) Date of service. 2) The signature of the person providing the service (or electronic equivalent); 3) The person's type of professional degree, licensure or job title. 4) Relevant identification number (e.g., NPI number), if applicable. 5) The date the documentation was entered in the medical record. (MHP Contract, Ex. A, Att. 9)
Reasons for Recoupment (RR): *Refer to the enclosed Recoupment Summary for additional details about disallowances.* RR16. The service provided was not within the scope of practice of the person delivering the service. (MHSUDS IN No. 17-050, Enclosure 4)

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

- The progress note was not signed by a provider whose scope of practice includes the provision of the service documented on the progress notes; i.e., the provider's scope of practice did not include delivering (e.g.) psychotherapy or medication support services: **Line number [33]. RR16, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5E:

[32] Line number(s) removed for confidentiality
[33] Line number(s) removed for confidentiality

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

1) All services claimed are provided by the appropriate and qualified staff within his or her scope of practice, if professional licensure is required for the service.
2) Staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.
3) Services are not claimed when they are provided by staff whose scope of practice or qualifications do not include those services.
4) 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 about disallowances.***

RR9. The service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation (e.g., Institution for Mental Disease [IMD], jail, and other similar settings, or in a setting subject to lockouts per CCR, Title 9, chapter 11).

RR11. The service provided was solely for one of the following:

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

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

FINDING 5E-2:

The following Line number had documentation indicating a Specialty Mental Health Service (SMHS) was provided while the beneficiary resided in a setting that was ineligible for Federal Financial Participation or resided in a setting subject to lockouts**:**

- Service was provided while the beneficiary resided in an Institution for Mental Disease, jail, or other similar settings. **Line number [34]**. **RR9, refer to Recoupment Summary for details.**

The progress notes for the following Line numbers indicate that the service provided was solely**:**

- Clerical: **Line number [35]**. **RR11f, refer to Recoupment Summary for details.**

[34] Line number(s) removed for confidentiality
[35] Line number(s) removed for confidentiality

PLAN OF CORRECTION 5E2:
The MHP shall submit a POC that describes how the MHP will ensure that:

1) Services provided and claimed are not solely transportation, clerical or payee related.
2) Services claimed were provided in a setting where the beneficiary was eligible for FFP or not subject to lockouts.

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

FINDING 6A:
1). The MHP did not furnish evidence that it has a standard procedure for providing individualized determinations of eligibility for ICC services and IHBS for beneficiaries under 22 years of age that is based on their strengths and needs.

2). The medical record associated with the following Line numbers did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS:

- **Line numbers [36].**

PLAN OF CORRECTION 6A:
The MHP shall submit a POC that describes how it will ensure that:

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

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

[36] Line number(s) removed for confidentiality

FINDING 6B:

1) The MHP did not furnish evidence that it has a procedure for reassessing the strengths and needs of children and youth, and their families, at least every 90-days, for the purpose of determining if ICC and/or IBHS should be added or modified.
2) The medical record for the following Line number(s) did not contain evidence that the MHP had reassessed the strengths and needs of the beneficiary, at least every 90 days, for the purpose of determining if ICC and/or IBHS should be added or modified:
   - **Line number [37].**

PLAN OF CORRECTION 6B:

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

1) Written documentation is in place describing the process for reassessing and documenting the eligibility and need for ICC and IHBS at least every 90-days for all beneficiaries receiving SMHS under the age of 22.
2) Training is provided to all staff and contracted providers who have the responsibility for determining eligibility and the need for the provision of ICC and IBHS.
3) Each beneficiary under the age of 22 who is receiving SMHS also receives a reassessment at least every 90-days of eligibility regarding their need for ICC and IHBS.

[37] Line number(s) removed for confidentiality