Glenn County
Plan of Correction

SECTION K: MEDICAL NECESSITY

ITEM N0.1:
Section K, "Chart Review - Non-Hospital Services," Question 1c-1:

PROTOCOL	
1c-1	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).

Findings

1c-1: The medical record associated with the following Line number 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):
Line number [1]. Reason for Recoupment #3.

Plan of Correction

ITEM #1, Section K, 1c-1:

Glenn County Mental Health's (GCMH) *Medical Necessity Criteria* policy, [2], mandates that all clients receiving specialty mental health services must meet the California Department of Health Care Services medical necessity criteria. The GCMH Medical Necessity Checklist is utilized to determine and document a client's medical necessity. This form is constructed from Title 9, chapter11 regulations on medical necessity criteria. Additionally, as according to the Medical Necessity Criteria policy, progress notes must indicate that the interventions focus on addressing significant functional impairment. Training on medical necessity criteria will occur in the annual GCMH Documentation Training, monthly staff unit meetings, and bi-weekly "Ask your QI Team" emails. Supervisors are now required to include oversight and training on documentation standards and medically necessary interventions during existing weekly individual supervision with staff.

ITEM NO. 2:
Section K, "Chart Review - Non-Hospital Services," Question 1c-2:

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

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PROTOCOL	
1c-2	**Do the proposed and actual intervention(s) meet the intervention criteria listed below:** **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.

Findings

1c-2: The medical record associated with the following Line numbers 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)(8)(1-4): Line number [3] Reason for Recoupment #4.

Plan of Correction

ITEM #2, Section K, 1c-2:

Glenn County Mental Health's (GCMH) *Medical Necessity Criteria* policy, [4], mandates that all clients receiving specialty mental health services must meet the California Department of Health Care Services medical necessity criteria. The GCMH Medical Necessity Checklist is utilized to determine and document a client's medical necessity. This form is constructed from Title 9, chapter 11 regulations on medical necessity criteria. Additionally, as according to the Medical Necessity Criteria policy, progress notes must indicate that the interventions focus on addressing significant functional impairment. Training on medical necessity criteria will occur in the annual GCMH Documentation Training, monthly staff unit meetings, and monthly "Ask your QI Team" emails. Supervisors are now required to include oversight and training on documentation standards and medically necessary interventions during existing weekly individual supervision with staff.

ITEM NO. 3:

Section K, "Chart Review - Non-Hospital Services," Question 2a:

PROTOCOL	
2a	**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? 2) Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency?

Findings

2a: Assessments were not completed in accordance with regulatory and contractual

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[4] Policy number(s) removed for confidentiality

requirements; specifically one or more assessments were not completed within the timeliness and frequency requirements specified in the MHP's written documentation standards. The following are specific findings from the chart sample: Line numbers [5]. The updated assessments were completed late.

Plan of Correction

ITEM #3, Section K, 2a:

GCMH's *Clinical Assessments* policy, [6], requires that assessments are updated at least annually for all clients, and as needed. In order to clarify the requirement for staff, the policy was revised to include specific language stating that "assessments are due annually on or before the anniversary date of the current treatment episode opening." Our policy has been revised, and is attached to this plan of correction. The QI department has been sending regular monthly reports of assessments that are coming due, and/or are overdue, and is now developing a process to ensure confirmation from both staff members and supervisors that these notifications are addressed by staff and are completed. The QI department will also include timeliness reminders part of regular monthly documentation and compliance training for staff. An additional step will be taken to resolve this deficiency through the implementation of action schedules within the EHR system utilized by GCMH, currently under devebpment, which will notify staff up to a month in advance of upcoming due dates for assessments

Timeframe for Completion:

4/10/17

ITEM NO. 4:
Section K, "Chart Review - Non-Hospital Services," Question 2b:

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

Glenn County
Plan of Correction

PROTOCOL	
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 **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 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.

Findings:

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 numbers [7].
2) Substance Exposure/Substance Use: Line numbers [8].
3) Client Strengths: Line number [9].
4) Risks: Line numbers [10].
5) A mental status examination: Line number [11].
6) A full DSM diagnosis or current ICD code: Line numbers [12].

Plan of Correction:

ITEM #4, Section K, 2b:

GCMH's *Clinical Assessments* policy, [13], requires that initial assessments include each of the required elements for clinical assessments as mandated by Title 9 regulations GCMH historically did not require annual re-assessments for open clients, but developed a process for yearly updates as part of best practices. While the initial assessment form remains in compliance with Title 9, chapter 11 regulations, the annual re-assessment update form was missing some required elements. GCMH has removed the form used for annual re- assessments and now use comprehensive Clinical assessments at both intake and annually. The current comprehensive assessments from both children/adolescents and adults, are compliant with all Title 9, chapter 11 regulations, and provide the necessary information to inform treatment. Training of staff regarding required elements of an assessment will occur in the annual GCMH Documentation Training, monthly staff unit meetings, and bi-weekly "Ask your QI Team" emails.

ITEM NO. 5:
Section K, "Chart Review - Non-Hospital Services," Question 3b:

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 anytime?

Findings:

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

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[8] Line number(s) removed for confidentiality
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[12] Line number(s) removed for confidentiality
[13] Policy number(s) removed for confidentiality

documented on the medication consent forms found in the beneficiary's medical record:

1) The reason for taking each medication: Line numbers [14].
2) Reasonable alternative treatments available, if any: Line numbers [15].
3) Type of medication: Line numbers [16].
4) Range of frequency: Line numbers [17].
5) Dosage: Line numbers [18].
6) Method of administration (oral or injection): Line numbers [19].
7) Duration of taking each medication: Line numbers [20].
8) Probable side effects: Line numbers [21].
9) Possible side effects if taken longer than 3 months: Line numbers [22].
10) Consent once given may be withdrawn at any time: Line numbers [23].

Plan of Correction:

ITEM #5, Section K, 3b:

GCMH's Consent for Services and Treatment with Medication policy, [24], outlines all of the required elements for medication consents per DHCS regulations. GCMH was previously using medication consent forms developed by Kings View, the agency that GCMH contracts with for tele-psychiatry services. The compliance deficiencies noted during this review were also noted by GCMH and addressed with Kings View. GCMH has opted to develop its own medication consent form that is fully compliant, and has consulted with a Kings View psychiatrist to develop language describing each of the required elements. The medication consent form will be available for electronic signatures within the EHR, as previously GCMH only used hard copy versions.

Timeframe for Completion:

12/10/16

ITEM NO. 6:

Section K, "Chart Review - Non-Hospital Services," Question 4a-1:

4a-1	1) **Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?**

Findings:

4a-1: 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): Line number [25]. The prior client plan was **late** per the MHP's written documentation standards. However, this occurred outside the audit review period.

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

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

Plan of Correction:

ITEM #6, Section K, 4a-1:

GCMH's *Client Treatment Plans* policy, #[26], mandates that all client treatment plans must be created in collaboration with the client, and contain a signature signifying the client's participation and agreement with the plan, within 60 days of episode opening. The QI department continues to provide monthly documentation trainings regarding this and other topics, as well as a bi-weekly email entitled "Ask Your QI Team." There is also a required annual documentation training that must be completed by all clinical staff. GCMH is currently implementing action schedules in the EHR that will notify staff of pending due dates for treatment plans, as well as assessments. The QI department has been sending regular monthly reports of treatment plans that are coming due, and/or are overdue, and now requires supervisors to check in with staff weekly about upcoming due dates, or overdue forms.

In addition to monthly documentation training, the annual documentation training will serve as a reminder to staff that all types of interventions/service modalities provided must be indicated on the treatment plan as proposed interventions, and be clear, specific, and address a client's identified functional impairment(s) as a result of their mental disorder. Monthly chart review will serve as the mechanism to monitor this.

GCMH established a process to prevent billing for services without an active client plan. Effective August 18, 2015, the initial interim service log entered into the EHR upon episode opening is now set to expire within 60 days, and no progress note can be added after this point until the client plan is completed. The EHR used by GCMH also does not allow for the entry of new progress notes upon expiration of the client plan, until a new plan is completed. Upon review of Line number [27] it was verified that the original plan for the review period was printed and signed on 5/22/14, with a revision to add group therapy written and signed on 3/10/15. There is one claim for medication support for 20 minutes on 5/21/14 that fell between the previous plan's expiration of 5/20/14 and the plan's signature date of 5/22/14. A copy of the request for disallowance is attached.

ITEM NO. 7:

Section K, "Chart Review - Non-Hospital Services," Question 4b:

[26] Policy number(s) removed for confidentiality
[27] Line number(s) removed for confidentiality

Glenn County
Plan of Correction

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.

Findings:

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-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 [28].

4b-2) One of 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.). Line number [29].

4b-3) One or more of the proposed interventions did not indicate an expected frequency. Line numbers [30].

4b-4) One or more of the proposed interventions did not indicate an expected duration. Line numbers [31].

Plan of Correction:

ITEM #7, Section K, 4b:

GCMH's *Client Treatment Plans* policy, [32], mandates that all client treatment plans must contain a specific, observable, and/or quantifiable goal and treatment objective, and that all treatment plans must contain the proposed frequency and duration of intervention(s). This policy also mandates that all treatment plans contain the proposed types of interventions/modalities. However, our policy at the time of the review did not have the verbiage "including a detailed description of the interventions to be provided." Our policy has since been revised, and is attached to this plan of correction. Training on measurable and quantifiable objectives related to the mental health needs and functional impairment of the beneficiary will occur in the annual GCMH Documentation Training, monthly staff unit meetings, and monthly "Ask your QI Team" emails.

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

Glenn County
Plan of Correction

Supervisors are now required to include oversight and training on documentation standards and establishment of observable and measurable treatment objectives during existing weekly individual supervision with staff.

ITEM NO. 8:
Section K, "Chart Review - Non-Hospital Services," Question 5a:

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? 5) Documentation of referrals to community resources and other agencies, when appropriate? 6) Documentation of follow-up care or, as appropriate, a discharge summary? 7) The amount of time taken to provide services? 8) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?

Findings:

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) 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 [33].

  5a-8) The provider's professional degree, licensure, or job title. Line numbers [34].

Plan of Correction:

ITEM #8, Section K, 5a:

GCMH's *Progress Notes and Late Entry Documentation* policy, [35] mandates that all services document relevant aspects of client care with a progress note and written by the end of the next

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

business day. With supervisor approval, progress notes may be written up to a maximum of three business days from the date of service. If there is an unforeseen incident, this policy grants authority to the Behavioral Health Director to approve the entry of a progress note beyond the 3 business day limit. The progress note completion date is the date the progress note was signed either electronically or with a handwritten signature by the staff member. All progress notes signatures include staff professional degree, licensure, or job title. GCMH now has safeguards via reports on late progress note entry in the EHR system. These reports are run bi-weekly, and any notes that are out of compliance for timeliness are removed from the billing process, and re-entered as informational notes by the staff.
Training on timeliness of documentation will occur in the annual GCMH Documentation Training, monthly staff unit meetings, and monthly "Ask your QI Team" emails.
Supervisors are now required to include oversight and training on documentation standards during existing weekly individual supervision with staff.

ITEM NO. 9:
Section K, "Chart Review - Non-Hospital Services," Question 5a3:

5a3	**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? 5) Documentation of referrals to community resources and other agencies, when appropriate? 6) Documentation of follow-up care or, as appropriate, a discharge summary? 7) The amount of time taken to provide services? 8) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?

Findings:
5a3: The progress notes for the following Line numbers indicate that the services provided were solely for:
- Clerical: Line numbers [36]. Reason for Recoupment #17.

Plan of Correction:
ITEM #9, Section K, 5a3:
GCMH's *Progress Notes and Late Entry Documentation* policy, [37], clearly defines excluded

[36] Line number(s) removed for confidentiality
[37] Policy number(s) removed for confidentiality

types of services. The Medical *Necessity Criteria* policy, [38], delineates medical necessity criteria. Progress note training on the provision of medically necessary interventions to treat a specific included diagnosis that will reduce impairment, restore functioning, or prevent significant deterioration in an important area of life functioning, as outlined in the client plan, as well as services that are excluded, will occur in the annual GCMH Documentation Training, monthly staff unit meetings, and monthly "Ask your QI Team" emails. Supervisors are now required to include oversight and training on medically necessary interventions and documentation standards during existing weekly individual supervision with staff.

ITEM N0. 10:
Section K, "Chart Review - Non-Hospital Services," Question 5b:

5b	**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?

Findings:

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:

- Progress notes did not 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. Line numbers [39].

Plan of Correction:

ITEM #10, Section K, 5b:

GCMH's *Progress Notes and Late Entry Documentation* policy, [40], states the following: "When services are being provided to, or on behalf of a beneficiary by two or more persons at one point in time, progress notes shall document each person's involvement in the context of the mental health needs of the beneficiary." Training on group note documentation to include medical necessity standards and the involvement or participation of multiple staff in a group setting will be provided during Annual GCMH Documentation training, monthly staff trainings, supervisor training and oversight, and bi-weekly "Ask Your QI Team," emails.

ITEM NO. 11:
Section K, "Chart Review - Non-Hospital Services," Question 5c:

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

5c	**Timeliness/frequency as follows:** 1) Every service contact for: A. Mental health services B. Medication support services C. Crisis intervention 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

Findings:

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

- There were no progress notes in the medical record for the services claimed. Line numbers [41]. Reasons for Recoupment #9.

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.

Plan of Correction:

ITEM #11, Section K, 5c:

GCMH's *Progress Notes and Late Entry Documentation* policy, [42], mandates that a progress note be written for every service provided. GCMH has implemented a progress note verification process via a report in the EHR which is run prior to sending in billing for services This report determines if a note has been written or not, and/or if the note was actually completed or entered as a blank form. Notes that have been written on paper such as emergency service notes, or notes written during computer outages, or while working in the field, are also identified by this report. Any note that cannot be verified as being completed electronically must be located and verified by a QI department staff member prior to it being allowed to be sent in for billing. If a note cannot be located, or it was determined that the note was not completed within timeliness standards the service is removed from billing and entered as an informational note in the medical record. Staff is continuously trained on this documentation requirement via the Annual GCMH Documentation Training, monthly QI trainings at staff meetings, and through bi- weekly "Ask Your QI Team," emails.

ITEM NO. 12:

Section K, "Chart Review - Non-Hospital Services," Question 5d:

[41] Line number(s) removed for confidentiality
[42] Policy number(s) removed for confidentiality

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 of documentation was entered in the medical record?

Findings:

5d: The Progress notes did not include:

- The provider's professional degree, licensure, or job title. Line numbers [43].
- The following Line numbers had progress notes indicating that the documented and claimed services provided were not within the scope of practice of the person delivering the service. Line numbers [44]. Reasons for Recoupment #19d.

Plan of Correction:

ITEM #12, Section K, 5d:

GCMH's *Progress Notes and Late Entry Documentation* policy, [45], mandates that all progress notes contain the provider's professional degree, licensure, or job title. Since most notes are signed electronically, the issue of missing these required elements was due to an error in the EHR, which has since been corrected. Staff is trained on scope of practice requirements through the Annual GCMH Documentation Training, monthly documentation trainings during staff meetings, and through the "Ask Your QI Team," email. Supervisors provide weekly oversight and monitoring for scope of practice issues. GCMH has created a specific policy that mandates scope of practice requirements entitled, *Staff Education and Experience Requirements, [46]*.

[43] Line number(s) removed for confidentiality
[44] Line number(s) removed for confidentiality
[45] Policy number(s) removed for confidentiality
[46] Policy number(s) removed for confidentiality