



REASONS FOR RECOUPMENT
FOR FY 2017/2018

(CCR, title 9, section 1810.380(b); Mental Health Plan (MHP) contract)

NON-HOSPITAL SERVICES

MEDICAL NECESSITY

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

CCR, title 9, sections 1830.205(b)(1)(A-R); 1830.210(a)(1), 1810.345(a) and 1840.112(b)(1)(4); Mental Health Plan (MHP) Contract; MHSUDS Information Notice 17-040

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

- a) A significant impairment in an important area of the beneficiary's life functioning
- b) A reasonable probability of significant deterioration in an important area of the beneficiary's life functioning
- c) A reasonable probability the child will not progress developmentally as individually appropriate
- d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

CCR, title 9, sections 1830.205(b)(2)(A – C), 1830.210(a)(3), 1810.345(a) and 1840.112(b)(1)(4)

3. 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

CCR, title 9, sections 1810.345(a); 1830.205(b)(3)(B), 1830.210(a)(3); and 1840.112(b)(4); MHP Contract

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CLIENT PLAN

4. No documentation of beneficiary or legal guardian participation and agreement with the client plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the Mental Health Plan (MHP) Contract with the Department.

CCR, title 9, sections 1810.440(c) and 1840.112(b)(5); MHP Contract; MHSUDS Information Notice 17-040

5. 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

An approved client plan must be in place prior to service delivery for the following SMHS:

- *Mental health services (except assessment, client plan development)*
- *Intensive Home Based Services (IHBS)*
- *Specific component of TCM and ICC: Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's individual needs*
- *Therapeutic Behavioral Services (TBS)*
- *Day treatment intensive*
- *Day rehabilitation*
- *Adult residential treatment services*
- *Crisis residential treatment services*
- *Medication Support (non-assessment/evaluation, non-plan development and non-urgent)*
- *Psychiatric Health Facility Services (Cal. Code Regs., tit. 22, § 77073.)*
- *Psychiatric Inpatient Services (Code Fed. Regs., tit. 42, § 456.180(a); Cal. Code Regs tit. 9 §§ 1820.230 (b), 1820.220 (l)(i))*

MHP Contract.; State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025), page 2c; MHSUDS Information Notice 17-040

PROGRESS NOTES

6. No progress note found for service claimed
- 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. For example, the progress note should indicate the SMHS, such as TCM, Medication Support, Crisis Intervention, etc.; and/or, the specific service activity when applicable, such as assessment, plan development, individual/group/family therapy, collateral, and rehabilitation, which would be claimed as Mental Health Services.
 - 2) Date of service, and/or
 - 3) Units of time.

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The exception below pertains to 6. b) 3):

- If everything in a progress note matches the claim except that the units of time documented in the progress note are greater than the units of time claimed, this will *not* result in a disallowance but will be a Plan of Correction (POC). If however, the units of time documented in the progress note are less than the units of time claimed, this will result in a disallowance.

The exceptions below pertain to 6. b) 1):

- If in review of a progress note one of the following is determined to be the case, the MHP will be allowed to void and replace the claim as long as all other progress note requirements are met.

The Specialty Mental Health Service and /or Service Activity was:

- (1) Claimed inaccurately by those entering/submitting claims information for the MHP, or
- (2) Documented inaccurately in the progress note by the provider of service.

If either of the above occurs, the MHP will be required to submit proof of the void and replace to the department for verification and a Plan of Correction will be required with evidence showing how the MHP will correct the identified problem and prevent future occurrences.

NOTE: This is expected to be the exception not the rule. If this is identified as a significant or repetitive finding it may result in disallowances.

CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), CCR, title 22, section 51458.1(a)(3)(4); MHP Contract ; CCR, title 9, section 1840.112(b)(3)

7. The progress note indicates that 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).

NOTE: When a beneficiary who resides in a setting in which s/he would normally be ineligible for Medi-Cal is moved off grounds to an acute psychiatric inpatient hospital or PHF, that individual again becomes Medi-Cal eligible (unless the hospital is free-standing with more than 16 beds and is thus considered an IMD and the beneficiary is between the ages of 21-64).

CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, part 435, sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d

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8. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (A dependent minor in a juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary, is Medi-Cal eligible. See CCR, title 22, section 50273(c)(5) A delinquent minor is only Medi-Cal eligible after adjudication for release into community. See CCR, title 22, section 50273(c)(1))

Code of Federal Regulations, title 42, sections 435.1009 – 435.1010; CCR, title 22, section 50273(a)(5-8), (c)(1, 5)

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

- a) Academic educational service
- b) Vocational service that has work or work training as its actual purpose
- c) Recreation
- 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

CCR, title 9, sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); title 22, chapter 3, section 51458.1(a)(5),(7);

10. The claim for a group activity, which is provided as a Mental Health Service, Medication Support, Crisis Intervention, or TCM service, was not properly apportioned to all clients present.

CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; MHSUDS Information Notice 17-040

11. 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,

CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; MHSUDS Information Notice 17-040

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

MHP Contract; MHSUDS Information Notice 17-040

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13. 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.

(NOTE: If there is a progress note in which the provider documents that they conducted chart review in preparation for a service, and documents that the beneficiary was a no-show for the service, the time spent to review the chart in preparation for the beneficiary’s appointment is reimbursable as plan development)

CCR, title 9, section 1840.112(b)(3); title 22, section 51470(a); MHSUDS Information Notice 17-040

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

CCR, title 9, section 1840.314(d); MHSUDS Information Notice 17-040

DAY TREATMENT INTENSIVE / DAY REHABILITATION (DTI / DR)

15. On a day where the beneficiary was present for at least 50% of the scheduled DTI/DR program time, but was not in attendance for the full hours of operation for that day, there is no documentation of the reason for an “unavoidable absence” which clearly explains why the beneficiary could not be present for the full program on the day claimed.

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;

16. The actual number of hours and minutes the beneficiary attended the DTI/DR program (e.g., 3 hours and 58 minutes) is not documented and for this reason it cannot be established that the beneficiary was present for at least 50% of the program time for the day reviewed.

DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;

17. Documentation reviewed, including the written weekly schedule for DTI/DR along with the progress notes, reflects that the program does not meet the time requirements for a half-day or full-day program as follows:

- a) Breaks and/or meal times were counted in order to meet the time requirements,

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- b) Half day program was less than 3 hours (requirement is for 4 hours or less, but a minimum of 3 hours)
- c) Full day program was 4 hours or less (requirements is for more than 4 hours)

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

18. 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

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

HOSPITAL SERVICES

MEDICAL NECESSITY

19. Admission

- a) Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).
- b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.
- c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:
 - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
 - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
 - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
 - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function

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- Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized

CCR, title 9, section 1820.205(a); See Also title 9, sections 1820.220, 1820.225 and 1820.230.

20. Continued Stay Services

- a) Documentation in the medical record does not establish the continued presence of a diagnosis contained in Section 1820.205(a)(1)(A-R)
- b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion
- c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires continued stay services in an acute psychiatric inpatient hospital for one of the following reasons:
 - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
 - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter
 - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
 - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
 - Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized
 - Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
 - Presence of new indications that meet medical necessity criteria specified in 22.a.above
 - Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital

CCR, title 9, section 1820.205—See Also title 9, sections 1820.220, 1820.225 and 1820.230.

ADMINISTRATIVE DAY REQUIREMENTS

21. Documentation in the medical record does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

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CCR, title 9, section 1820.205(b), See Also sections 1820.220(a)(5), (l)(5)(A), 1820.230(a)(2), (d)(1),(2)(A).

22. Documentation provided by the MHP does not establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital does not document contacts with a minimum of five (5) appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements:
- a) The MHP or its designee may waive the requirement of five (5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one (1) contact per week.
 - b) The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:
 - i. The status of the placement option
 - ii. The date of the contact
 - iii. Signature of the person making the contact

CCR, title 9, sections 1820.220(a)(5), (l)(5)(B), 1820.230(d)(2)(B)

CLIENT PLAN

23. The medical record does not contain a written plan of care (also referred to as a client plan) for a beneficiary.

Code of Federal Regulations, title 42, section 456.180; CCR, title 9, section 1820.210

24. The physician did not establish a written plan of care (or client plan) prior to the authorization of payment, which must be done either by the MHPs Point of Authorization prior to admission of the beneficiary or by the hospital Utilization Review Committee or its designee, "no later than the third working day from the day of [the beneficiary's] admission."

NOTE: The physician's signature and date on the written plan of care indicates their establishment of the plan.

Code of Federal Regulations, title 42, section 456.180(a); CCR, title 9, sections 1820.210, 1820.220(a)(1) and 1820.230(a)(1), (2) and (b)

OTHER

25. A hospital day was claimed and paid (1) on which the beneficiary was not a patient in the hospital or (2) for the day of discharge, neither of which is reimbursable.

CCR, title 9, section 1840.320(b)(1), (3); Title 22, section 51470(a)