MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES
ON-SITE REVIEW FY 2016-2017
Date5/01/17 - 05/04/17

TRINITY COUNTY POC EVIDANCE
REPORT TO DHCS

07/23/17 DHCS findings from Audit via Plan of Correction (POC)
09/30/17 TCBHS Submission of POC to DHCS
Progress Implementation Dates

SECTION	COMMENT	DATE COMPLETED
Item No. 1 Section B; Access, B**9a2, B9a3**	Test Call #4 The DHCS test caller requested information about how to access SMHS in the county. The operator said that he/she could talk to the caller about how the caller is feeling and could perform a brief intake over the phone, but then requested to put the caller on hold for two (2) minutes. Upon the operator's return, the operator informed the caller that he/she had to attend to someone in crisis and requested that caller to call back in fifteen (15) minutes to be enrolled for SMHS. ***Finding:*** *The caller was not provided information about how to access SMHS. The caller was not provided information about services needed to treat a beneficiary's urgent condition.* 07/23/17 POC MHP is required to provide evidence to DHCS to substantiate its POC and 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 SHMS 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. **09/30/17 MHP response:** While TCBHS continues to provide a statewide, toll-free telephone number (888)624-5820,	**Progress: Implementation to be completed by 12/31/17**

24 hours a day, 7 days per week, with language capability in all languages spoken by beneficiaries of the county, we have commenced specific training for all crisis/triage workers and reception staff, anyone who may answer our toll-free access line phone, including afterhours phone line responders, in how to provide more complete information to beneficiaries about

- how to access SMHS, including how to briefly assess whether SMHS medical necessity criteria are met,
- services needed to treat a beneficiary's urgent condition, including information about immediate services via 911 emergency care, and how to access the closest hospital, and
- how to use the beneficiary problem resolution and hair hearing processes to capture <u>every call received</u> and provide thorough timely, and immediate responses.

See attached script and training material (P&P 2313 and form 2313.1)

Finding: The MHP did not furnish evidence of its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation – The logs made available by the MHP did not include all required elements for calls.

Item No. 2 Section B; Access, B10a

07/23/17 POC The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial request for SMHS (including requests made via telephone, in person or in writing) complies with all regulatory requirements.

Progress: Implementation to be completed by 12/31/17

09/30/17 MHP response:
TCBHS has created a more comprehensive logging system for calls made, those in person, or in writing to address acknowledgement and informing materials given out regarding initial requests for SMHS. The log is electronically managed to be completed by front office staff having been trained in requirements of logging initial requests by telephone, in writing, or in person. In addition, TCBHS will rewrite the associated P&P 2309 for "Medi-Cal Access Line", and P&P 2313 "Script and Protocol for Answering and Logging Daytime Access Line Calls". This P&P will include

	required elements including the required inclusion of the name of the beneficiary, date of the request, and initial disposition of the request. see (P&P 2309 and 2313) TARs must be approved or denied within 14 calendar days Finding: Of 19 samples reviewed, 2 were found out of compliance due to dates being beyond the 14 day response requirement. **Finding:** Question C1c was found in partial compliance	
Item No. 3 Section C; Authorizations, C1c,	07/23/17 POC The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with regulatory requirement regarding TARs for non-hospital SMHS services. **09/30/17 MHP response:** TCBHS has improved days to response for TAR's with the use a routing system whereby each stage of the process from the date the TAR is received, initialed and dated from receipt by mail to the authorization by Medical Director and ultimately final approval by Deputy Director of Clinical Services; tracked by initialing and dating each step along the path. P&P 3206 has been updated with the procedure as indicated. (see attached policy3206 and Routing for MH Hospitalization Records form)	**Progress: Implementation completed**
Item No. 4 Section C; Authorizations, C2c,	For standard authorization, the MHP must 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. **Finding:** <u>With regard to SARs MHP makes authorization decisions and provides notice within 14 days – 3 of 19 samples were out of compliance.</u> 07/23/17 POC The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with regulatory requirement regarding SARs for non-hospital SMHS services. **09/30/17 MHP response:** TCBHS staff are more closely following requirements to respond to SAR requests within the 14 calendar day limit. Additionally, a SAR log is being kept electronically by	**Progress: Implementation completed**

	date received and their disposition by date processed. MHP's P&P 3002,3004 Log is reviewed by Clinical Deputy Director on a quarterly basis for validity and timeliness. (See copy of SAR log sample)	
Item No. 5 Section C; Survey Only C4d,	**Survey Finding:** DHCS reviewed the following documentation provided by the MHP for this survey Item: P&P#: 3002 – Access to Non-Emergency Services for out of county Beneficiaries; P&:#: 3008- Expedited Intake Assessment; P&P#: 3003 – Clinical Intake Process; and SAR Request Tracking Sheet. The documentation lacks specific elements to demonstrate compliance with federal and State requirements. Specifically, P&P#:3002 – Access to Non-Emergency Services for out of county Beneficiaries should be updated to reflect timely transfer within 48 hours of authorization to demonstrate compliance with federal and State requirements. 07/23/17 Suggested Actions DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: MHP needs to update P&P#: 3002 – Access to Non-Emergency Services for out of county Beneficiaries to reflect timely transfer within 48 hours of authorization to demonstrate compliance with federal and state requirements. **09/30/17 MHP response:** TCBHS will update P&P#: 3002 to reflect <u>timely transfer</u> of out of county emergency services within 48 hours of authorization to demonstrate compliance with federal and state requirements.	**Progress: Implementation to be completed by 12/31/17**
Item No. 6 Section H; Survey Only H5a3.	Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing) providers and contractors are not in the Social Security Administration's Death Master File? 07/23/17 Suggested Actions DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirement: Implement a process to verify new and current provider, and contractors are not in the Social Security Administration's Death Master File. **09/30/17 MHP response:**	**Progress: Implementation to be completed by 12/31/17**

TCBHS will update P&P#: 2801 to implement method of verification that all providers and contractors (current and new) are not listed on the Social Security Administration's Death Master File prior to contracting or employing individuals to demonstrate compliance with federal and State requirements.
Finding: Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

One or more assessments were not completed within the update frequency requirements

Specified in the MHP's written documentation standards..

07/23/17 POC 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 requirement specified in the HHP's written documentations standards.

09/30/17 & 2/18 MHP response:

Item No. 7 Section K Chart Review Finding 2a

TCBHS has implemented a more thorough utilization review of charts whereby each provider's caseload is examined by another staff member to assure due dates including assessment updates for consumers are timely or will be reported to the Deputy Director of Clinical Services for further action. The Utilization Review (UR) sub-committee will meet at least monthly; they will monitor the Medi-Cal Chart Review requirements each year and make adjustments to the Chart Review form as needed per Medi-Cal policy.

Progress: Implementation to be completed by 12/31/17

Monthly, the UR Supervisor or his/her designee, will review 20 or more internal charts (those charts maintained within the Agency). All completed chart review forms are due by the end of the month to the Clinical Director. The UR Supervisor, or his/her designee will review all charts for each provider's caseload at least semi-annually to assure due dates including assessment updates are timely, or findings will be reported to the Deputy Director of Clinical Services for further action and/or training. Reviews may also be completed on all or a sample of charts prior to a staff person leaving the Agency.

The UR Supervisor will provide feedback to staff and monitor any patterns that require improvement. The UR Supervisor will bring compliance problems to the

awareness of the UR Committee. The committee may request a re-review of the chart to ensure that the issues have been addressed. Patterns or trends may also indicate the need for staff training, either one-on-one or as a team.

TCBHS maintains a process for disallowing claims for services that do not meet medical necessity up to and including recoupment.

(See attached revised P&P #: 2002)

Item No. 8 Section K Chart Review Finding 3b	**Finding:** 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 to have been reviewed with the beneficiary: 4) Frequency/frequency range: Lines numbers [1] 5) Dosage/dosage range: Lines numbers [2] 6) Method of Administration (e.g., oral or injection): Line numbers [3] 7) Duration of taking each medication: Line numbers [4]	**Progress: Implementation completed**

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

10) Consent once given may be withdrawn <u>at any time</u>: Line numbers [5].
07/23/17 POC 3b **Note:** The MHP submitted Medication Consent Policy #3109 dated 4/4/2017 as well as a draft revision of this policy together with a (draft) revised Medication Consent document. These draft revisions included all elements that were missing from the Medication Consent documents reviewed as part of the current chart review (see **<u>FINDING 3b</u>**, above for missing elements). Therefore, the Plan of Correction required for Finding 3b is limited to the MHP's submission of the following:

- The final, revised Medication Consent Policy/Procedure, together with a copy of the final version of its revised Medication Consent Form.
- Evidence of any trainings pertaining to the revised Medication Consent materials (i.e. training dates, example training materials, staff & contracted providers attending, etc.).
- The date that the revised materials and procedure will be or has been implemented.

09/30/17 & 2/18 MHP response:
TCBHS submits herein the final version of Medication Consent P&P#: 3109 (approved 4/4/17), Final Version of the Informed Medications Consent form (approved 10/2017), and an example of a Medication Guide.
Medication Consent Form:
Page 1
page 2

Example of Medication Guide (available for all medications prescribed by the Psychiatrist):

Item No. 9 Section K Chart Review Finding 4a2

Finding: The client plan was not updated at least annually, or reviewed and updated if there was a significant change in the beneficiary's mental health condition (as required in the MHP Contract with the Department).

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

[5] Line number(s) removed for confidentiality

07/23/17 POC 4a2 The MHP shall submit a POC that describes how the MHP will:

1) Ensure that client plans are completed at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and update frequencies specified in the MHP's written documentation standards.
2) Ensure that all interventions/modalities recorded on client plans are clear, specific and address the beneficiary's current functional impairments as a result of the mental disorder.
3) Ensure that non-emergency services are not claimed when:
   a) A client plan has not been completed.
   b) The series provided is not included on the current client plan.
4) Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.
5) Ensure that client plans are reviewed and updated whenever there is sa significant change in the beneficiary's condition.

Progress: Implementation to be completed by 12/31/17

09/30/17 & 2/18 MHP response:

TCBHS has implemented a more thorough utilization review of charts whereby each provider's caseload is examined by another staff member to assure due dates including assessment updates for consumers are timely or will be reported to the Deputy Director of Clinical Services for further action. The Utilization Review (UR) sub-committee will meet at least monthly; they will monitor the Medi-Cal Chart Review requirements each year and make adjustments to the Chart Review form as needed per Medi-Cal policy.

Monthly, the UR Supervisor or his/her designee, will review 20 or more internal charts (those charts maintained within the Agency). All completed chart review forms are due by the end of the month to the Clinical Director. The UR Supervisor, or his/her designee will review all charts for each provider's caseload at least semi-annually to assure due dates including assessment updates are timely, or findings will be reported to the Deputy Director of Clinical Services for further action and/or training. Reviews may also be completed on all or a sample of charts prior to a staff person leaving the Agency.

The UR Supervisor will provide feedback to staff and monitor any patterns that require improvement. The UR Supervisor will bring compliance problems to the awareness of the UR Committee. The committee may request a re-review of the chart to ensure that the issues have been addressed. Patterns or trends may also indicate the need for staff training, either one-on-one or as a team.

TCBHS maintains a process for disallowing claims for services that do not meet medical necessity up to and including recoupment. If anything is found to be out of compliance during chart reviews, the finding is reported to the Clinical Director for training needs, and to the Medical Records Coordinator to begin the recoupment or disallowance process.
(See attached revised P&P #: 2002)

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

- The MHP was not following its own written documentation standards for timeliness of progress notes.
- Progress notes did not document the following:
  5a-1) Line numbers [6]: 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 number [7]: No service provided. The MHP acknowledged that a duplicate service was claimed and documented by the same provider on two (2) separate progress notes with the same date of services.
- Line numbers [8]: Amount of time claimed did not include all eligible activities recorded on the corresponding progress note – i.e. documentation and travel times.

Item No. 10 Section K Chart Review Finding 5a

Progress: Implementation to be

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

07/23/17 POC 5a: The MHP shall submit a POC that describes how the MHP will: **completed by 12/31/17**

1) Ensure that progress notes meet timeliness, frequency and staff signature requirements in accordance with regulatory and contractual requirements.
2) Ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.
3) Ensure that the same service is not duplicated o more than one (1) progress note and is not claimed by the same provider on the same date of services.
4) The MHP shall submit a POC that describes how the MHP will ensure that:
   5a-1) Progress Notes are completed within the timelines specified in the MHP's written documentation standards by the person providing the service.
   5a-4) Units of time claimed include all billable activities that are recorded on the corresponding progress note – i.e., direct service, documentation and travel times.

09/30/17 & 2/18 MHP response:

TCBHS has implemented a more thorough utilization review of charts whereby each provider's caseload is examined by another staff member to assure due dates are timely or will be reported to the Deputy Director of Clinical Services for further action. In the course of providing billable services, Case Managers and Clinicians shall utilize the Progress Note as a method to record the activities of each billable service. The Progress Note shall be dated and the modality of service should be recorded. The total number of minutes rendered for the service, the writing of the Progress Note, and travel time shall all be individually recorded. The Progress Note shall begin with a statement about the current status of the consumer and an update about the main concern the consumer has presented in the current session. The middle portion of the Progress Note shall be directed to interventions used and progress made toward the objectives stated in the Treatment Plan. The Progress Note shall also reflect the response of the consumer to the interventions used. The Progress Note shall end with a plan for the next treatment session including date, if scheduled.

The Progress Notes are required to be submitted within three (3) working days (Holidays and flex days are excluded in this calculation). If a Progress Note is

entered late, the date of the rendered service shall be recorded, and the date of the entry into the chart shall be noted. It will also read, “Late Note”.

The Utilization Review Committee will review dates of service on client notes to identify possible trends regarding “Late Note” findings. Any such findings may result in negative response in an employee evaluation, or disciplinary action.

(See attached revised P&P #: 2002)

Finding: The progress note for the following Line number indicated that the service provided was solely a clerical activity:
07/23/17 POC 5a3: The MHP shall submit a POC that describes how the MHP will ensure that:

1) Services claimed and documented on a progress note are not solely clerical in nature.
2) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairment and are medically necessary as delineated in the CCR, title 9, chapter 11, 1830.205(a)(b).

Item No. 11 Section K Chart Review Finding 5a3

Progress: Implementation to be completed by 12/31/17

09/30/17 & 2/18 MHP response:
On June 7 and June 21, 2017, TCBHS Agency Director provided to all clinical staff an internal training on examples of billable versus clinical services, as well as copies of state guidelines for Medi-Cal billable services. Ongoing trainings will be provided to all new staff regarding chart documentation and Medi-Cal services. TCBHS has implemented a more thorough utilization review of charts whereby each provider’s caseload is examined by another staff member to assure due dates including assessment updates for consumers are timely or will be reported to the Deputy Director of Clinical Services for further action. (See attached revised P&P #: 2002)

Item No. 12 Section K Chart Review Finding 5b

Finding: 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:

	• Line number [9]: One or more progress notes did not document the, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary. 07/23/17 POC 5b: The MHP shall submit a POC that describes how the MHP will endure that: 1) Group progress notes clearly document the contribution, involvement or participation of each member as it relates to identified functional impairment and mental health needs of the beneficiary. 2) There is medical necessity for the use of multiple staff in the group setting. **09/30/17 & 2/18 MHP response:** TCBHS was not aware of the correct documentation for groups led by two or more facilitators. The Agency has since provided education and training on documentation with two group facilitators. Due to staffing levels, TCBHS is not currently offering groups with more than one facilitator. TCBHS has implemented a more thorough utilization review of charts whereby each provider's caseload is examined by another staff member to assure due dates are timely or will be reported to the Deputy Director of Clinical Services for further action. (See attached revised P&P #: 2002)	**Implementation to be completed by 12/31/17**
Item No. 13 Section K Chart Review Finding 5c	**Finding:** Line number [10]: There was no progress note in the medical record that matched the service claimed. • Line number [11]: The data recorded on eight (8) progress notes for group sessions did not match the units of time claimed for the beneficiary who attended the group did not match the units of time claimed for the beneficiary who attended the group. 07/23/17 POC 5b: 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) Actually provided to the beneficiary. c) Claimed for the correct service modality, billing code and unites of time.	**Progress: Implementation to be completed by 12/31/17**

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

2) Ensure that all progress notes:
   a) Are accurate, complete and meet the documentation requirements described in the MHP Contract with the Department.
   b) Indicate the type of service, the date of service and the amount of time taken to provide the service as specified in the MHP Contract with the Department.

09/30/17 & 2/18 MHP response:

TCBHS has been working with the EHR System to find out how we may correctly enter and claim group information within the Anasazi system. The Clinical Director also provided direct one-on-one training regarding group documentation to staff who needed more guidance in this area.

In the course of providing billable services, Case Managers and Clinicians shall utilize the Progress Note as a method to record the activities of each billable service. The Progress Note shall be dated and the modality of service should be recorded. The total number of minutes rendered for the service, the writing of the Progress Note, and travel time shall all be individually recorded. The Progress Note shall begin with a statement about the current status of the consumer and an update about the main concern the consumer has presented in the current session. The middle portion of the Progress Note shall be directed to interventions used and progress made toward the objectives stated in the Treatment Plan. The Progress Note shall also reflect the response of the consumer to the interventions used. The Progress Note shall end with a plan for the next treatment session including date, if scheduled.

The Progress Notes are required to be submitted within three (3) working days (Holidays and flex days are excluded in this calculation). If a Progress Note is entered late, the date of the rendered service shall be recorded, and the date of the entry into the chart shall be noted. It will also read, “Late Note”.

The Utilization Review Committee will review dates of service on client notes to identify possible trends regarding “Late Note” findings. Any such findings may result in negative response in an employee evaluation, or disciplinary action.