REASONS FOR RECOUPMENT FOR FY 2012-2013

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, chapter 11, section 1830.205(b)(1)(A-R).

   CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R); CCR, title 9, chapter 11, section 1810.345(a); CCR, title 9, chapter 11, section 1840.112(b)(1)(4)

2. Documentation in the medical record does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, 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 life functioning
   b) A probability of significant deterioration in an important area of life functioning
   c) A 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, chapter 11, section 1830.205(b)(2)(A – C); CCR, title 9, chapter 11, section 1830.210(a)(3)

3. Documentation in the medical record does not establish that the focus of the proposed intervention is to address the condition identified in CCR, title 9, chapter 11, section 1830.205(b)(2)(A),(B),(C)-(see below):

   a) A significant impairment in an important area of life functioning
   b) A probability of significant deterioration in an important area of life functioning
   c) A 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, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

4. Documentation in the medical record does not establish the expectation that the proposed intervention 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

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d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition

CCR, title 9, chapter 11, section 1830.205(b)(3)(B); CCR, title 9, chapter 11, section 1810.345(c)

CLIENT PLAN:

5. Initial client plan was not completed within the time period specified in the MHP's documentation guidelines, or lacking MHP guidelines, within 60 days of the intake unless there is documentation supporting the need for more time.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract

6. The client plan was not completed, at least, on an annual basis or as specified in the MHP's documentation guidelines.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract

7. No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract

8. For beneficiaries receiving Therapeutic Behavioral Services (TBS), no documentation of a plan for TBS.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, DMH Letter No. 99-03, Pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51458.1(a)(3); MHP Contract

10. The time claimed was greater than the time documented.

    CCR, title 9, chapter 11, section 1810.440(c); CCR, *title 9, chapter 11, sections 1840.316 - 1840.322; CCR, title 22, chapter 3, section 51458.1(a)(3)(4)(5); CCR, title 22, chapter 3, section 51470(a); MHP* Contract

11. 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. Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11.)

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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*

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).

    CFR, title 42, sections 435.1008 – 435.1009; CCR, title 22, section 50273(a)(1-9)

13. 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

    CCR, title 9, chapter 11, section 1840.312(a-d); CCR, title 9, chapter 11, section 1810.247; CCR, title 22, chapter 3, section 51458.1(a)(5)(7)

14. The claim for a group activity was not properly apportioned to all clients present.

    CCR, title 9, chapter 11, section 1840.314(c); CCR, title 9, chapter 11, section 1840.316(b)(2)

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

    MHP Contract

16. The progress note indicates the service provided was solely transportation.

    CCR, title 9, chapter 11, section 1810.355(a)(2), CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); DMH Letter No. 02-07

17. The progress note indicates the service provided was solely clerical.

    CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

    CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

19a. No service was provided.

    CCR, title 9, chapter 11, section 1840.112(b)(3); DMH Letter No. 02-07; CCR, title 22, chapter 3, section 51470(a)

19b. The service was claimed for a provider on the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE).

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CFR, title 42, section 438.610; Social Security Act, sections 1128 and 1156; USC, title 42, chapter 7, subchapter XI, part A, sections 1320a-5 and 1320a-7

19c. The service was claimed for a provider on the Medi-Cal suspended and ineligible provider list

CCR, title 9, chapter 11, section 1840.314(a); Welfare and Institutions Code, sections 14043.6, 14043.61 and 14123;

19d. The service was not provided within the scope of practice of the person delivering the service.

CCR, title 9, chapter 11, section 1840.314(d)

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:
    a) For the convenience of the family, caregivers, physician, or teacher
    b) To provide supervision or to ensure compliance with terms and conditions of probation
    c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
    d) To address conditions that are not a part of the child's/youth's mental health condition

    DMH Letter No. 99-03

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

    DMH Letter No. 99-03

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. 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

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- 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

CCR, title 9, chapter 11, section 1820.205(a)

23. 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, chapter 11, section 1820.205

ADMINISTRATIVE DAY REQUIREMENTS:

24. 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.
25. Documentation provided by the Mental Health Plan (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

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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 fewer 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, chapter 11, section 1820.230(d)(2)

CLIENT PLAN:

26. The medical record does not contain a client plan.

CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

27. The client plan was not signed by a physician.

CFR, title 42, section 456.180: CCR, title 9, chapter 11, section 1820.210

OTHER

28. 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, chapter 11, section 1840.320(b)(1)(3)