DEPARTMENT OF HEALTH CARE SERVICES
REVIEW OF PLACER MENTAL HEALTH PLAN
DECEMBER 3-4, 2018
CHART REVIEW FINDINGS REPORT -- AMENDED

Chart Review – Non-Hospital Services

The medical records of five/ten (5/10) adult and five/ten (5/10) 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 Sonoma 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 407 claims submitted for the months of October, November and December of **2017**.

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Medical Necessity

REQUIREMENTS

The beneficiary must meet medical necessity criteria outlined in subsections (1-3) to be eligible for services. (CCR, title 9, § 1830.205(b).)

1) The beneficiary meets DSM criteria for an included ICD diagnosis for outpatient SMHS in accordance with the MHP contract. (MHSUDS IN Nos., 15-030, 16-016, 16-051, and 17-004E)

2) The beneficiary must have at least one of the following impairments as a result of the mental disorder or emotional disturbance (listed above in A1):

1. A significant impairment in an important area of functioning.
2. A probability of significant deterioration in an important area of life functioning.
3. A probability that the child will not progress developmentally as individually appropriate
4. 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.

(CCR, title 9, § 1830.205 (b)(2)(A-C).)

3) The proposed and actual intervention(s) meet the intervention criteria listed below:

a) The focus of the proposed and actual intervention(s) addresses 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 the SMHS can correct or ameliorate per No. 1 (b)(4). (CCR, title 9, §

b) 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.
(CCR, title 9, § 1830.205 (b)(3)(B)(1-4).)

B. The condition would not be responsive to physical health care based treatment. (CCR, title 9, § 1830.205(b)(3)(C).)

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

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 3a:
The medical record associated with the following Line number(s) did not meet medical necessity criteria since the focus of the intervention(s) did not address the mental health condition, as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A):

- **Line number(s) [1]. RR15b refer to Recoupment Summary for details.**

PLAN OF CORRECTION 3a:
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 must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation.

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

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

RR2. Services, except for Crisis Intervention and/or services needed to establish medical necessity criteria, 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. The MHP did not submit documentation substantiating the beneficiary's need for services was established by an Assessment.

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

FINDING 2A:
Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

1) One or more assessments were not completed within the timeliness and/or frequency requirements specified in the MHP's written documentation standards, which requires assessments to be performed within 60 days from the date of admission. The following are specific findings from the chart sample:

    - **Line number [2]:** The initial assessment was completed late.

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

- **Line number [3]:** The assessment was due on [4], based on MHP 60 day policy for initial Assessments. The Assessment was completed [5].

- **Line number [6]:** The MHP documented that the beneficiary's last episode of treatment was closed on [7]. The MHP provided evidence of a Discharge Summary dated [8], including the reason for discharge, "Client has completed Treatment." The MHP documented that the beneficiary returned to services with a new admission date of [9]; however, the assessment was completed beyond the MHP's standard of 60 days on [10].

- **Line number [11]:** The MHP documented the beneficiary's admission to be [12]; however, the current assessment is dated prior to admission on [13]. The MHP provided a progress note for a Targeted Case Management service dated [14], which documented the reasons the beneficiary requested to return to care.

- **Line number [15]:** The admission date was [16]. The assessment was documented to have started on [17] and completed [18], more than 60 days from the admission date.
- **Line number [19]:** The admission date was [20]. The assessment was completed [21] with diagnosis date of [22].

- **Line number [23]:** The updated assessment was completed late.

  - **Line number [24]:** See above, item **1)**.
  - **Line number [25]:** The updated assessment was completed 3 days late.

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- **Line number [26]:** See above, item **1)**.
- **Line number [27]:** The updated assessment was completed 11 days late.

PLAN OF CORRECTION 2A:

The MHP shall submit a POC that:

1) Describes how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

2) Clarifies the MHP's policy regarding the use of assessments for clients who are closed and then re-opened to services within a reasonable period of time; including how to document the presenting problem/reason for returning to services, current mental status examination, and any other updates to ensure the beneficiary's recommended course of treatment is based on a current 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 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;

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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 2B:
One or more of the assessments reviewed did not address all of the elements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

- Mental Health History: **Line number [28].**
- Medical History: **Line number(s) [29].**
    - **Line number [30]:** The beneficiary is documented as having sustained multiple head injuries. The documentation stops short of providing detail with regard to the recentness of these events, whether or not these events have impact on the beneficiary's current mental health condition, and recommendations for their course of treatment.
    - **Line number [31]:** The beneficiary is documented as having a history of stroke, seizures/epilepsy and head injury; however, there is not clear documentation regarding the recentness of these events, the severity and current medical stability of the beneficiary and whether or not the beneficiary is receiving medications pertaining to the injury. These physical health considerations are relevant to the mental health diagnostic considerations and for appropriate recommendations for course of treatment.
    - **Line number [32]:** The beneficiary is documented as having physical conditions, including: Back injury, migraines, nerve damage and neuropathy in legs, pancreatic disease, joint injuries, sleep disturbance, sugar levels (diabetes), etc. These conditions are not documented on the current Diagnosis Form. The documentation in the assessment does not provide detail with regard to

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consideration of the beneficiary's physical health as it relates to their mental health condition. These physical health considerations are relevant to mental health diagnostic considerations and for appropriate recommendations for course of treatment.

- **Line number [33]:** The beneficiary is documented as having enuresis, with episodes present during the day and at night. The documentation does not provide detail about whether or not these events are attributed to a medical condition, if the beneficiary is receiving treatment, and what impact (if any) these episodes have on the beneficiary's current mental health condition. Specifically, section "4. Medical: What health care visits has child/youth had in past 6 months?" there is a check "x" in the "Other" category, without further detail.

- Substance Exposure/Substance Use: **Line number [34].**
- A mental status examination: **Line number [35].**
- A full diagnosis from the current ICD code: **Line numbers [36].**
  - **Line number [37]:** The diagnosis on the [38] Diagnosis Form included a rule out for Posttraumatic Stress Disorder. This rule out is maintained on the [39] Diagnosis Form; however, the assessment documentation does not provide a clear rationale.
  - **Line number [40]:** The assessment start date and diagnosis form are both dated [41]; however, the assessment was not completed until [42]. It is not clear what factors/elements of the assessment the clinician took into consideration to make a diagnostic determination, before completing the assessment.
  - **Line number [43]:** The current assessment is dated [44] with the diagnosis section dated [45] (prior to the last assessment date of [46]). There is a note within the diagnosis section "Updated per [sic] on [47]. See chart for updated ICD-10." The MHP provided the progress note referenced in this section, for the updated diagnosis information.

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Notably, the diagnosis in the assessment for [48] is dated [49]. The way these details are being documented in the record is confusing. It is not clear how the diagnosis section of the assessment is linked to the other elements of the assessment document. Refer to Information Notice 17-040, Section B, Item 3.

PLAN OF CORRECTION 2B:

1) The MHP shall submit a POC that describes how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department.

2) The MHP shall submit a POC that describes how the MHP will ensure that every assessment element is sufficiently addressed, in order to ensure a fully informed diagnostic determination and to provide appropriate recommendations for the beneficiary's course of treatment.

3) The MHP shall submit a POC that describes how the MHP will ensure that every assessment element is current and linked to the other assessment elements.

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Medication Consent

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 number(s) [50]**: There was no written medication consent form found in the medical record. *The MHP did not submit all required medication consent documentation, as requested.*
   - **Line number [51]:** The documentation in the beneficiary's record identified Cogentin as a current prescription (reference progress note [52]).
   - **Line number [53]:** The documentation in the beneficiary's record identified Zoloft as a current prescription (reference progress note [54]).
   - **Line number [55]:** The documentation in the beneficiary's record identified Lamotrigine as a current prescription (reference progress note [56]).
   - **Line number [57]:** The documentation in the beneficiary's record identified Depakote as a current prescription (reference progress note [58]).
   - **Line number [59]:** The documentation in the beneficiary's record identified Invega Sustenna as a current prescription (reference progress note [60]).

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.

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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:

- Range of Frequency: **Line number [61].**
- Dosage: **Line number [62].**
- Method of administration (oral or injection): **Line number [63].**
- Duration of taking each medication: **Line number [64].**
- Possible side effects if taken longer than 3 months: **Line number(s) [65].**

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.

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.

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(MHP Contract, Ex. A, Attachment 9)

Finding 3C:
Medication Consent(s) 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:

- Signature of the person providing the service (or electronic equivalent):
  - **Line number [66].**
- The type of professional degree, licensure, or job title of person providing the service:
  - **Line number [67].**
- The date the documentation was entered in the medical record:
  - **Line number [68].**

PLAN OF CORRECTION 3C:
The MHP shall submit a POC that describes how the MHP will ensure that all documentation includes**:**

1) The signature of the qualified person (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.
2) The date the documentation was entered into the medical record.

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)

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

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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 4A:

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 [69]:** The initial client plan was not completed until after treatment services were claimed. **RR4a, refer to Recoupment Summary for details.**
- **Line number [70]**: The initial client plan was completed late, according to the MHP standards; however, this occurred outside of the audit review period.
- **Line numbers [71]**: There was a **lapse** between the prior and current client plans and therefore, there was no client plan in effect during a portion or all of the audit review period. **RR4b, refer to Recoupment Summary for details.**
- **Line numbers [72]**: There was a **lapse** between the prior and current client plans. However, this occurred outside of the audit review period.
- **Line number [73]**: There was a **lapse** between the prior and current client plans. However, no services were claimed.
- **Line number [74]**: There was **no** client plan for one or more type of service being claimed. **RR4c, refer to Recoupment Summary for details**
- **Line number [75]:** The Client Plan dated [76] is *identical* to the current Client Plan dated [77]. It is not clear that the current Client Plan has been updated based on the beneficiary's need for services, established by an assessment.

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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 updated at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.
3) Ensure that planned services are not claimed when the service provided is not included in the current client plan.
4) Ensure the client plan is updated at least annually, to address the beneficiary's needs as established by a current assessment.

REQUIREMENTS

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 number [78]:** The treatment goal did not appear to correspond to the beneficiary's mental health condition ADHD, Unspecified. The goal, included "taking a nap and/or getting good sleep; getting on social media to occupy his mind; and talking to positive, healthy, friends/people online from 1 time per day to 3 times per day as measured by self-report, the caretakers and/to the WRAParound team."
- One or more of the proposed interventions did not include a detailed description.

[78] Line number(s) removed for confidentiality

Line numbers [79].

- **For Example, Line number [80]:** Interventions are generically written and repeated across goals. Specificity is lacking with regard to which of the beneficiary's needs is being addressed and how the interventions will be applied to meet that need. For example, the Targeted Case Management intervention is written, "…Individual Therapy (if deemed clinically appropriate, minimum 10-12 sessions)…TCM to include linkage to appropriate community resources, such as Health 360, PCP, dentist, Medi-Cal, SSI, etc."

- One or more of the proposed interventions did not indicate an expected frequency. **Line numbers [81].**
- One or more of the proposed interventions did not indicate an expected duration. **Line numbers [82].**
- 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 numbers [83].**
  - **Line number [84]:** The interventions do not note which functional impairments are being addressed and by which service activity.
  - **Line number [85]:** The Client Plan includes the statement, "Services include but [*may not be limited to*]: individual/group therapy, housing support, independent living skills, connection to community resources, crisis support, team meetings, and prosocial skill development." It is not clear what services the beneficiary requires to meet their needs. For example, the current assessment documentation indicates that the beneficiary's housing situation has been stable over the last year.

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 focusing on and addressing the beneficiary's identified functional impairments.

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3) Every mental health intervention proposed on a client plan indicates both an expected frequency and duration.
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

The MHP shall ensure that Client Plans include documentation of the beneficiary's participation in and agreement with the Client Plan. (MHP Contract, Ex. A, Att. 9; CCR, title 9, § 1810(c)(2).)

The MHP shall ensure that Client Plans include the beneficiary's signature or the signature of the beneficiary's legal representative when:
a) The beneficiary is expected to be in long-term treatment, as determined by the MHP, and,
b) The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS.

(CCR, title 9, § 1810.440(c)(2)(A).)

When the beneficiary's signature of the signature or the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan includes a written explanation of the refusal or unavailability of the signature. (CCR, title 9, § 1810.440(c)(2)(B).)

FINDING 4E:

There was no documentation of the beneficiary's or legal representative's degree of participation in and agreement with the client plan, and there was no written explanation of the beneficiary's refusal or unavailability to sign the plan, if the signature was required by the MHP Contract with the Department and/or by the MHP's written documentation standards**:**

- **Line numbers [86].**

PLAN OF CORRECTION 4E:

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

1) Ensure that each beneficiary's participation in and agreement with all client plans are obtained and documented, as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2).
2) Ensure that the beneficiary's signature is obtained on the client plan, as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2)(A)(B).

[86] Line number(s) removed for confidentiality

3) Ensure that services are not claimed when the beneficiary's:
    a) Participation in and agreement with the client plan is not obtained and the reason for refusal is not documented.
    b) Signature is not obtained when required or not obtained and the reason for refusal is not documented.

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 numbers [87].**

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.
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:

One of the Client Plans reviewed in the chart sample, **Line number [88]**, did not include the signature of the person providing the service (or electronic equivalent) with the person's professional degree, licensure, or job title.

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.

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Progress Notes

REQUIREMENTS

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.***

RR6. The MHP did not submit documentation substantiating the expectation that the 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; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

RR7. The progress note does not describe how services provided to the beneficiary reduced impairment, restore 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.

(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. (MHP Contract, Exhibit A, Attachment 9) Below are the specific findings pertaining to the charts in the review sample:

- **Line number [89]:** Although group rehabilitative services were a planned service on the beneficiary's client plan, the nutrition group was not found to be medically necessary, as the focus of the group did not correspond to the beneficiary's functional impairments as described in the current Assessment. **RR 6, refer to Recoupment Summary for details.**

- **Line number [90]:** There is no description of the service intervention provided to the beneficiary. Specifically, there was no documentation noting the intervention applied on the part of the therapist during the Individual Therapy service dated [91]. **RR 7, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5A:
The MHP shall submit a POC that describes how the MHP will ensure that services provided to the beneficiary reduced impairment, restored functioning, or 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.

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 number(s) 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 [92].**
- Timeliness of the progress note could not be determined because the note was signed but not dated by the person providing the service. Therefore, the date the progress note was entered into the medical record could not be determined, and the note was considered to be late. **Line numbers [93].**

[89] Line number(s) removed for confidentiality
[90] Line number(s) removed for confidentiality
[91] Date(s) removed for confidentiality
[92] Line number(s) removed for confidentiality
[93] Line number(s) removed for confidentiality

- Progress notes did not document the interventions applied, beneficiary's response to the interventions and the location of the interventions. **Line number [94].**

PLAN OF CORRECTION 5B:

1) 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.
    - The date the progress note was completed and entered into the medical record by the person(s) providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.
    - Interventions applied, the beneficiary's response to the interventions and the location of the interventions, as specified in the MHP Contract with the Department.

2) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning.

3) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).

4) Speciality Mental Health Services claimed are actually provided to the beneficiary.

REQUIREMENTS

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

a) Every Service Contact:

i. Mental Health Services;

ii. Medication Support Services;

iii. Crisis Intervention;

iv. Targeted Case Management;

[94] Line number(s) removed for confidentiality

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.

(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 number(s)** [95]: The type of specialty mental health service (SMHS) (i.e., Targeted Case Management) documented on the progress note was not the same as the type of SMHS claimed (i.e. Collateral). **RR8b1, refer to Recoupment Summary for details.**

[95] Line number(s) removed for confidentiality

- **Line number(s)** [96]: For Mental Health Services claimed, the service activity (e.g., Assessment, Plan Development, Rehab) identified on the progress note was not consistent with the specific service activity actually documented in the body of the progress note.

  - **Line numbers** [97]**:** Family Therapy claimed; however, the beneficiary was not present for the service (Collateral Service).
  - **Line number** [98]**:** TCM claimed for ICC intervention(s) on [99], [100], and [101].
  - **Line number** [102]: The service activity was Assessment; however, the claim was for Family Psychotherapy. Targeted Case Management documented; however, Collateral claimed.
  - **Line number** [103]: Family Therapy claimed; however, there was no clear documentation of the family being present during the services. The documentation content is Plan Development (reference progress note [104]).
  - **Line numbers** [105]: Family Therapy claimed and client not present during services (i.e., Collateral services).
  - **Line number** [106]: Collateral service claimed; however, documentation content was Assessment (reference progress note [107]).

PLAN OF CORRECTION 5D:
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) Appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).
   d) Claimed for the correct service modality billing code, and units of time.
2) Ensure that all progress notes:
   a) Are accurate, complete and meet the documentation requirements described in the MHP Contract with the Department.

[96] Line number(s) removed for confidentiality
[97] Line number(s) removed for confidentiality
[98] Line number(s) removed for confidentiality
[99] Date(s) removed for confidentiality
[100] Date(s) removed for confidentiality
[101] Date(s) removed for confidentiality
[102] Line number(s) removed for confidentiality
[103] Line number(s) removed for confidentiality
[104] Date(s) removed for confidentiality
[105] Line number(s) removed for confidentiality
[106] Line number(s) removed for confidentiality
[107] Date(s) removed for confidentiality

b) Describe the type of service or service activity, the date the service was provided and the amount of time taken to provide the service, as specified in the MHP Contract with the Department.

c) Are completed within the timeline and frequency specified in the MHP Contract with the Department.

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 indicated that one of the intervention service activities being provided was not within the scope of practice of the person delivering the service:

- **Line number [108]:** While the Rehabilitation service activity being provided was within the scope of practice of the person signing the progress note, a component of the service documentation was not, specifically the Mental Status Examination.

PLAN OF CORRECTION 5E:

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

1) All documentation includes the signature or (electronic equivalent) with the professional degree, licensure or title of the person providing the service.
2) All documentation includes the date of service, the date the signature was completed and the document was entered into the medical record.
3) 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.
4) Staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.

[108] Line number(s) removed for confidentiality

5) Services are not claimed when they are provided by staff whose scope of practice or qualifications do not include those services.
6) 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.*

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 5E2:

The progress note(s) for the following Line number(s) indicate that the service provided was solely**:**

- Clerical: **Line number(s) [109]**. **RR11f, refer to Recoupment Summary for details.**

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 clerical.
2) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).

[109] Line number(s) removed for confidentiality