Imperial County Behavioral Health Services

Fiscal Year (FY) 21/22 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

The MHP must meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. Triennial review will focus on timeliness of all urgent appointments and physician appointments.

1. Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment
2. Urgent care appointments for services

Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i).

DHCS Finding 1.1.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP met the Department standards for timely access to urgent care appointments. Per the discussion during the review, the MHP's access line staff are trained to screen for urgent conditions and beneficiaries can receive services within 60 minutes. Post review, the MHP submitted its fiscal year 2021-2022 QI work plan, a urgent conditions request log, and a psychiatry timeliness log. Of the 50 urgent requests reviewed post review, it was not evident that (1) request met the timeliness requirement as the time of service was not included in the log.

Corrective Action Description

The Quality Management Unit will provide training to the Access Unit to ensure staff assigned to answer the 24/7 Beneficiary Access Line appropriately screen callers to determine the urgency of need for services. Staff will be trained to ensure that calls are screened appropriately and that appointments are made available within the applicable timeliness standards (urgent care appointments without prior authorization – 48 hours; urgent care appointments requiring authorization – 96 hours; psychiatry appointments – 15 days).

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline:

Requirement

The MHP must provide TFC services to all children and youth who meet medical necessity criteria for TFC.

Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care Services (TFC) for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

DHCS Finding 1.2.7

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it is currently not providing TFC services. The MHP had been working to establish a TFC services provider in the county, however, due to the contractor experiencing extenuating circumstances a contract could not be established.

Corrective Action Description

The MHP shall assess children and youth beneficiaries to determine medical necessity for TFC. In the event a beneficiary is determined to meet the need for TFC, the MHP shall notify the Imperial County Department of Social Services via referral in order for the child to be placed in a foster home that is qualified to provide TFC.

Proposed Evidence/Documentation of Correction

Updated procedure, TFC assessment, and referral form.

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline:

DHCS Response:

Action Required:

Requirement

The MHP must have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC.

Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care Services (TFC) for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

DHCS Finding 1.2.8

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth to determine if they meet medical necessity criteria for TFC. Per the discussion during the review, the MHP stated that it uses the California Child and Adolescent Needs and Strengths (CANS) assessment tool and the Pediatric Symptom Checklist (PSC) assessment tool to screen for TFC. The MHP stated samples TFC assessments would be provided post review as evidence. Post review, the MHP provided three (3) CANS and three (3) PSC screening samples, however, the assessments do not assess criteria specific to TFC medically necessity requirements.

Corrective Action Description

All youth will be assessed for TFC eligibility at the time of initial intake assessment and re-assessment using TFC screening criteria established in the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP shall update procedures and provide training to all clinical staff regarding the requirements to assess all children and youth to determine if they meet medical necessity criteria for TFC.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline:

Action Required:

Requirement

The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request.

California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f).

DHCS Finding 4.3.4

While the MHP submitted evidence to demonstrate compliance with this requirement, one (1) of five (5) required DHCS test calls was not logged on the MHP's written log of initial request and one (1) did not include the beneficiary's name. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	11/29/2021	2:40 p.m.	OOC	IN	IN
2	11/30/2021	7:44 a.m.	IN	IN	IN
3	12/20/2021	7:26 a.m.	IN	IN	IN
4	1/20/2022	3:38 p.m.	IN	IN	IN
5	1/21/2022	8:03 a.m.	OOC	OOC	OOC
Compliance Percentage			**60%**	**80%**	**80%**

Corrective Action Description

In order to ensure that all incoming calls and in-person requests are logged in the AVATAR Access V3 log, Access has taken proactive measures to ensure that protocols were received by the staff. Additionally, the protocols for Access Log V3 and Access Telephone

line were reviewed on 7/28/22 with the entire Access staff during the monthly staff meeting. As part of the meeting, the supervisor reviewed and read protocols, and copies of the protocols were distributed to all members of staff. The protocols can be found in the share folder of the Access Unit. A further step will be taken by Quality Management and Access Supervisor to ensure that staff are in compliance with Access V3 log entry requirements at all times by conducting more test calls. The program/office supervisor will ensure that all newly hired staff members are properly trained before they answer our ICBHS 24-hour telephone line. Access monthly meetings will continue to include a reminder for staff about the importance of logging all calls.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

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Person Responsible (job title)

Implementation Timeline:

Requirement

The MHP must provide beneficiaries with a Notice of Adverse Beneficiary Determination under the circumstances listed below:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.
2. The reduction, suspension or termination of a previously authorized service.
3. The denial, in whole or in part, of a payment for service.
4. The failure to provide services in a timely manner.
5. The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

Federal Code of Regulations, title 42, section 438, subdivision 400.

DHCS Finding 5.4.1

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides Notice of Adverse Beneficiary Determinations (NOABDs) to beneficiaries for the denial or limited authorization for a service based on medical

necessity or for the failure to provide services in a timely manner. Per the discussion during the review, beneficiaries receive urgent services within 60 minutes of request. An urgent conditions request log was provided post review to demonstrate compliance for timeliness of urgent services. Of the 50 urgent service requests reviewed, it was not evident if one (1) request required a NOABD or if a NOABD was sent to the beneficiary.

Corrective Action Description

The MHP shall provide training to all staff regarding the requirements to issue a NOABD whenever the MHP:

1. Denies or limits authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.
2. Reduces, suspends, or terminates a previously authorized service.
3. Denies, in whole or in part, of a payment for service.
4. Fails to provide services in a timely manner.
5. Fails to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. Denies a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline:

Action Required:

Chart Review

Requirement

All entries in the beneficiary record (i.e., Assessments) 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) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9, Sec. 1(D)(2)(a)-(c).)

DHCS Finding 8.2.3

One assessment reviewed did not include the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title. Specifically:

- **Line number 5. Assessment completed on 11/9/2020**

The MHP shall submit a CAP that describes how the MHP will ensure that all documentation includes**:**

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

Corrective Action Description

Training will be provided to all clinical staff on Policy 01-133 Documentation Standards by March 31, 2023, to ensure all assessments include the signature with the professional degree, licensure, or title of the person providing the service, and the date the signature was completed and the document was entered into the medical record.

Proposed Evidence/Documentation of Correction

Training presentation and attendance.

Ongoing Monitoring (if included)

Supervisors, upon review of intakes, will confirm that all required signatures and titles are present in each assessment report. The Compliance Unit will also check for provider signature and date of signature on assessments when conducting chart reviews.

Person Responsible (job title)

Program Supervisors and the Compliance Unit.

Implementation Timeline:

Action Required:

Requirement

All entries in the beneficiary record (i.e., Assessments) 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) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9, Sec. 1(D)(2)(a)-(c).)

DHCS Finding 8.2.3a

Three assessments reviewed did not include the signature or co-signature (or electronic equivalent) of a provider, operating under their scope of practice who was eligible to determine or complete the following assessment elements: 1) diagnosis, 2) Mental Status Exam, 3) medication history, and 4) assessment of psychosocial factors

- **Line number 1**. LVN independently completed an assessment on 7/13/2020
- **Line number 7.** MHRS independently completed an assessment on 8/11/2020
- **Line number 8.** LVN independently completed an assessment on 9/10/2020

The MHP shall submit a CAP that describes how the MHP will ensure that all Assessments which include a mental health diagnosis and/or a Mental Status Exam and/or a medication history and/or relevant psychosocial factors contain**:**

1) The signature (or electronic equivalent) of a person qualified to determine or document the required assessment elements listed above
2) The signature of the qualified person (or electronic equivalent) with their professional degree, licensure or credential.

3) The date the signature was completed and the document was entered into the medical record.

Corrective Action Description

The MHP shall provide training to all staff regarding the required elements for initial intake assessment and subsequent re-assessments. The MHP will ensure the assessments include the following elements:

1) The signature (or electronic equivalent) of a person qualified to determine or document the required assessment elements listed above
2) The signature of the qualified person (or electronic equivalent) with their professional degree, licensure or credential.
3) The date the signature was completed and the document was entered into the medical record.

Policies and procedures will be updated to reflect the above and training will be provided to all Clinical staff to ensure they are aware of all required elements that must be included in the assessment.

Proposed Evidence/Documentation of Correction

Training presentation, training attendance, and updated policies and procedures.

Ongoing Monitoring (if included)

Person Responsible (job title)

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Implementation Timeline

Requirement

Written medication consents shall include, but not be limited to, 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, Att. 9, Sec. 1(D)(4).)

DHCS Finding 8.3.2

Six out 14 medication consents reviewed (57% compliance) did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not recorded on the medication consent form, and/or were not otherwise documented to have been reviewed with the beneficiary.

1) The reason for taking each medication: **Line numbers 3 and 7.**
2) Reasonable alternative treatments available, if any: **Line numbers 3, 4 and 7.**
3) Type of medication: **Line number 7.**
4) Frequency or Range of Frequency (of administration): **Line number 3.**
5) Method of administration: **Line numbers 3 and 5.**
6) Duration of taking the medication: **Line numbers 1, 4 and 7.**
7) Probable side effects: **Line numbers 3, 4 and 7.**
8) Possible side effects if taken longer than 3 months: **Line numbers 1, 3, 4 and 7.**
9) Consent once given may be withdrawn at any time: **Line numbers 1, 3, 4, 5 and 7.**

The MHP shall submit a CAP 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.

Corrective Action Description

The MHP shall review consent requirements with all Medical Professionals (MD and NP) to include the following sections:

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.

Additionally, the MHP is in the process of finalizing an electronic medication consent. Once complete and pilot period ends, we will be able to fully implement. This will assist in ensuring all required elements are included.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline

Requirement

All entries in the beneficiary record (i.e., Medication Consents) 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) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9, Sec. 1(D)(2)(a)-(c).)

DHCS Finding 8.3.3

Two medication consents in the chart sample did not include the signature of the provider of service (or electronic equivalent) that includes the provider's professional degree, licensure, job title, and/or the date the provider completed and entered the document into the medical record. Specifically:

- The signature of the person providing the service (or electronic equivalent)
  - **Line number 9.**
- The professional degree, licensure, or job title of person providing the service:
  - **Line numbers 2 and 9.**
- The date the documentation was completed, signed (or electronic equivalent) and entered into the medical record:
  - **Line number 9.**

The MHP shall submit a CAP that describes how the MHP will ensure that all Medication Consents include the:

1) Provider's signature (or electronic equivalent).
2) Provider's signature (or electronic equivalent) that includes professional degree, licensure or title.
3) Date the signature was completed and the document was entered into the medical record.

Corrective Action Description

The MHP shall review consent requirements with all Medical Professionals (MD and NP) to include the following sections:

- The signature of the person providing the service (or electronic equivalent)
- The professional degree, licensure, or job title of person providing the service:
- The date the documentation was completed, signed (or electronic equivalent) and entered into the medical record.

The MHP is also in the process of implementing electronic medication consents which will assure client and provider signature/title and date is included in all consents.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline:

Requirement

Services (i.e., Plan Development) shall be provided within the scope of practice of the person delivering service, if professional licensure is required for the service. Services shall be provided under the direction of one or more of the following:

A. Physician
B. Psychologist
C. Licensed Clinical Social Worker
D. Licensed Marriage and Family Therapist
E. Licensed Professional Clinical Counselor
F. Registered Nurse, including but not limited to nurse practitioners, and clinical nurse specialists

G. Waivered/Registered Professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver.

(CCR, tit. 9, § 1840.314(e), 1810.440(c); State Plan, Supplement 3, Attachment 3.1-A, pp. 2m-p; MHSUDS IN No. 17-040.)

DHCS Finding 8.4.4

Services were not provided within the scope of practice of the person delivering service, if professional licensure is required for that service. Specifically:

• Two progress notes were not signed by a provider whose scope of practice includes the provision of the service documented on the progress note; i.e., the provider's scope of practice did not include delivering (e.g.) Psychotherapy or Medication Support Services: **Line number 2. RR3, refer to Recoupment Summary for details.**

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

1) All documentation includes the signature or (electronic equivalent) along with the provider's professional degree, licensure or title.

2) All documentation includes service date and dated signature (or electronic equivalent) in order to indicate when the provider completed and entered the document into the medical record.

3) All services claimed are provided by the appropriate and qualified persons within their scope of practice.

4) All providers adhere to the MHP's written documentation standards and procedures for limiting services to those within the providers' scope of practice.

5) Services are not claimed when they are provided by a provider whose scope of practice, credentials or qualifications do not include those services.

6) All claims for services delivered by any person who was not qualified to provide those services are disallowed.

Corrective Action Description

The MHP will review scope of practice with Mental Health Rehabilitation Staff to ensure:

1. All services claimed are provided by the appropriate and qualified persons within their scope of practice.
2. All providers adhere to the MHP's written documentation standards and procedures for limiting services to those within the providers' scope of practice.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

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Person Responsible (job title)

Implementation Timeline:

Requirement

Items that shall be contained in the client record (i.e., Progress Notes) related to the beneficiary's progress in treatment include all of the following:

1) Timely documentation of relevant aspects of client care, including documentation of medical necessity.
2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions.
3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions.
4) The date the services were provided.
5) Documentation of referrals to community resources and other agencies, when appropriate.
6) Documentation of follow-up care or, as appropriate, a discharge summary
7) The amount of time taken to provide services.
8) The following:
    a) The signature of the person providing the service (or electronic equivalent);
    b) The person's type of professional degree, and,
    c) Licensure or job title.

(MHP Contract, Ex. A, Att. 9, Sec. 1(C)(1)(a)-(h).)

DHCS Finding 8.5.1

Progress notes did not include all required elements specified in the MHP Contract, and/or were not in accordance with the MHP's written documentation standards. Specifically:

• **Line numbers 5 and 6.** The Units of Time for 16 Crisis Residential service claims were recorded as "0" on the claim although the "approved" dollar amounts equaled one (1) day of residence for all 16 claims. In addition, we found progress notes which corresponded with all of these claims:

• **Line number 10.** One progress note did not match its corresponding claim in terms of amount of time to provide services: The service time documented on the Progress Note was less than the time claimed, or the service time was entirely missing on the Progress Note. **RR7, refer to Recoupment Summary for details. (***Pursuant to CCR title 9 section 1840.316 (b)(1) The exact number of minutes used by the persons providing a reimbursable service shall be reported and billed. As such these*

services are to be claimed with the actual and specific number of minutes for each service, and are not to be rounded up in 15-minute increments.)

• **Line numbers 2, 4, 5, 7, 8 and 9.** Ten progress notes were missing the provider's professional degree, licensure or job title.(i.e., 5 percent of the total progress notes reviewed)

1) The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document**:**

• Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.
• The provider's/providers' professional degree, licensure or job title.

2) The MHP shall submit a CAP that describes how the MHP will ensure that the Units of Time recorded on claims submitted correspond to the dollar amounts claimed and match the times recorded on their corresponding progress notes.

3) The MHP shall submit a CAP that describes how the MHP will ensure that Specialty Mental Health Services claimed are accurate and are actually provided to the beneficiary.

Corrective Action Description

1. Training will be provided to all clinical staff on Policy 01-133 Documentation Standards by March 31, 2023, to ensure timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards and the provider's/providers' professional degree, licensure or job title are included.
2. Upon investigation, the Fiscal Unit determined that progress notes reflected (1) unit but the level of Service Fee/Cross Reference Maintenance: Unit of Measurement Code in the EHR was incorrectly set up generating inaccurate units in the 837p file. The system issue has been corrected in the EHR to ensure that the units of time recorded on claims submitted correspond to the dollar amounts claimed and match the times recorded on their corresponding progress notes.
3. Training will be provided to all clinical staff on Policy 01-133 Documentation Standards to ensure that Specialty Mental Health Services claimed are accurate and actually provided to the beneficiary.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline:

Requirement

Progress notes shall be documented at the frequency by type of service indicated below:
1) Every service contact for:
    A. Mental health services
    B. Medication support services
    C. Crisis intervention
    D. Targeted Case Management
    E. Intensive Care Coordination
    F. Intensive Home Based Services
    G. Therapeutic Behavioral Services
2) Daily for:
    A. Crisis residential
    B. Crisis stabilization (one per 23-hour period)
    C. Day treatment intensive
    D. Therapeutic Foster Care
3) Weekly for:
    A. Day treatment intensive (clinical summary)
    B. Day rehabilitation
    C. Adult residential

(MHP Contract, Ex. A, Att. 9, Sec. 1(C)(2)(a)-(c).)

DHCS Finding 8.5.3

Progress notes were not documented according to the contractual requirements specified in the MHP Contract. Specifically:

- **Line numbers 4 and 5.** The type of Specialty Mental Health Service (SMHS) (e.g., Medication Support, Targeted Case Management) documented on the progress note was not the same type of SMHS claimed. **RR5, refer to Recoupment Summary for details.**

The MHP shall submit a CAP that describes how the MHP will:
1) Ensure that all Specialty Mental Health Services claimed are:
    a) Documented in the medical record.
    b) Actually provided to the beneficiary.
    c) Claimed for the correct service modality billing code, and units of time.

2) Ensure that all progress notes:
    a) Are accurate, complete and legible and meet the documentation requirements described in the MHP Contract with the Department.

b) Describe the type of service or service activity, the date of service and the amount of time 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, and as specified in the MHP's written documentation standards.

Corrective Action Description

The MHP shall train and reinforce with clinical staff the use of correct service modality billing code based on the type of service provided (i.e. mental health service H2015= 60 or medication support service H2010=30).

The MHP shall reinforce the correct service modality billing code for mental health services and targeted case management services and direct staff to complete two different progress notes for each type of service modality (i.e. MHS vs TCM).

The MHP shall provide refresher training to clinical staff to:

1) Ensure that all Specialty Mental Health Services claimed are:
   a) Documented in the medical record.
   b) Actually provided to the beneficiary.
   c) Claimed for the correct service modality billing code, and units of time.

2) Ensure that all progress notes:
   a) Are accurate, complete and legible and meet the documentation requirements described in the MHP Contract with the Department.
   b) Describe the type of service or service activity, the date of service and the amount of time 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, and as specified in the MHP's written documentation standards.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline:

Requirement

The MHP must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs.

(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3rd ed. 2018), p. 9.)

DHCS Finding 8.6.1

1) The MHP did not furnish evidence that it has a standardized procedure for documenting individualized determinations of eligibility for ICC services and IHBS on behalf of beneficiaries under age 22 that is based on their strengths and needs.

2) The medical record associated with the following Line numbers did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS and that, if appropriate, such services were included on their Client Plan:

- **Line number 6.** An Assessment completed on 8/6/2020 contains an IHBS/ICC services section which was left blank, and there was no other evidence in the chart materials submitted that an intentional IHBS/ICC service determination was performed. During the virtual onsite review, the MHP explained that *this section is left blank when an IHBS/ICC determination indicated that the beneficiary was not in need of those services.* This process appears to be problematic and open to unintentional errors.
- **Line number 8.** The Assessments completed on 10/18/2019 and 9/10/2020 contain an IHBS/ICC service section which was left blank, and there was no other evidence in the chart materials submitted that an intentional IHBS/ICC service determination was performed.
- **Line number 9.** There was no evidence in the chart materials submitted that at least one (1) IHBS/ICC service determination was performed prior to or during the chart review period.
- **Line number 10.** The Assessment completed on 10/21/2020 contains an IHBS/ICC services section which was left blank, and there was no other evidence in the chart materials submitted that an intentional IHBS/ICC service determination was performed.

The MHP shall submit a CAP that describes how it will ensure that:

1) The MHP amends its existing policy (or other relevant materials) to include a written procedure describing the process for determining and documenting eligibility and need for ICC Services and IHBS for all beneficiaries under age 22 meeting medical necessity for Specialty Mental Health Services.

2) This procedure includes a standard, explicit and clear method for documenting that an ICC/IHBS determination was completed even when the beneficiary was determined not to need IHBS and/or ICC services.

3) The MHP provides training to all staff and contract providers who are responsible for determining eligibility and need for IHBS and/or ICC services.

4) All ICC/IHBS determinations are documented in a clear and uniform manner as part of the beneficiary's medical record.

Corrective Action Description

1. As of June 2021, the MHP EHR was updated to include ICC and IHBS eligibility criteria as part of the Assessment. This was included as a mandatory field that could not be bypassed by staff conducting the assessment or re-assessment.
   Policy 01-227 Intake Assessment and Re-Assessment and Procedure 01-131 Initial Intake Assessment – New or Readmit will be updated by March 2023 to describe the process for determining and documenting eligibility and need for ICC and IHBS Services for all beneficiaries under age 22 meeting medical necessity for Specialty Mental Health Services.
2. Policy 01-227 Intake Assessment and Re-Assessment and Procedure 01-131 Initial Intake Assessment – New or Readmit will be updated by March 2023 to include a standard, explicit and clear method for documenting that an ICC/IHBS determination was completed even when the beneficiary was determined not to meet criteria for ICC and/or IHBS services.
3. The MHP provided training on June 14, 2021, to all staff who are responsible for determining eligibility and need for ICC and/or IHBS services.
4. The Intake Assessment Form will be updated in the electronic health record (EHR) to include a mandatory field in which staff must clearly document ICC/IHBS determination.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline:

Requirement

The ICC Coordinator and the CFT reassesses the strengths and needs of children and youth, and their families, at least every 90 days, and as needed.

(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3rd ed. 2018), p. 26; MHSUDS IN No. 18-007.)

DHCS Finding 8.6.2

The MHP did not furnish evidence that it has a specific procedure for beneficiaries under age 22 who are receiving ICC services to receive a reassessment, during a CFT or other meeting, of the strengths and needs of these beneficiaries and their families at least every 90-days for the purpose of determining if ICC services and/or IBHS should be increased, reduced or otherwise modified.

The MHP shall submit a CAP that describes how it will ensure that:

1) Written documentation is in place describing the process for reassessing and documenting the eligibility and need for IHBS and ICC services at least every 90-days for all beneficiaries who are already receiving ICC services.

2) All staff and contract providers who have the responsibility for determining eligibility and need for the provision of ICC services receive training about ICC service requirements.

3) All beneficiaries under age 22 who receive ICC services have a case consultation, team or CFT meeting at least every 90 days to discuss the beneficiaries' current strengths and needs.

Corrective Action Description

1. A procedure for determining Medical Necessity for ICC and IHBS services will be created in support of Policy 01-329 Determining Medical Necessity for ICC, IHBS, and TFC to assess at least every 90-days for the purpose of determining if ICC and/or IHBS services should be increased, reduced or modified.
2. MHP will provide training to clinical staff and contract providers on new procedure for determining Medical Necessity for ICC and/or IHBS services.
3. New procedure for determining Medical Necessity for ICC and IHBS services will include case consultation, team or CFT meeting at least every 90 days to discuss

the beneficiaries' current strengths and needs for determining if ICC services and/or IHBS should be increased, reduced or modified.

Proposed Evidence/Documentation of Correction

Ongoing Monitoring (if included)

Person Responsible (job title)

Implementation Timeline: