Lake County Behavioral Health Services

Fiscal Year (FY) 20/21 Specialty Mental Health Triennial Review

Corrective Action Plan

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Chart Review

Medical Necessity

Finding 8.1.1.1

Line numbers 5 and 8. The diagnosis was not linked in time as an addendum to the assessment. Specifically:

- Line number 5. Diagnosis completed on 5/1/2017; Crisis Assessment completed on 3/3/2019.
- Line number 8. Diagnosis completed on 6/1/2016; Assessment completed on 3/30/2020.

Requirement
The MHP shall submit a CAP that describes how the MHP will ensure that the diagnosis is linked in time to the assessment and is consistent with the presenting problems, history, mental status examination, and/or other clinical data documented in the assessment.

Corrective Action Description
Policies #141 (Medical Necessity Criteria) and #142 (Clinical Assessment and Reassessment Standards) will be updated to clarify accurately documenting diagnoses and assessments, including linking the diagnosis in time to the assessment. LCBHS will provide quarterly training to clinical staff on this standard. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide quarterly training to clinical staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized quarterly for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.1.1.3b

The actual interventions documented in the progress note(s) for the following Line number(s) did not meet medical necessity criteria since the intervention(s) were not

reasonably likely to result in at least one of the following: a) significantly diminish the impairment; b) prevent deterioration in an important area of life functioning; c) allow the child to progress developmentally; d) correct or ameliorate the mental health condition of a beneficiary who is under age 21. Specifically:

- **Line numbers 3 and 7.** The intervention documented on the progress note did not meet the definition of a valid Specialty Mental Health Service. **RR15b, refer to Recoupment Summary for details.**

Requirement
The MHP shall submit a CAP that describes how the MHP will ensure that all SMHS interventions are reasonably likely to correct or reduce the beneficiary's documented mental health condition, prevent the condition's deterioration, or help a beneficiary who is under age 21 to progress developmentally as individually appropriate.

Corrective Action Description
Policy #146 (Progress Notes) will be updated to clarify standards around appropriate interventions that meet medical necessity criteria and accurately documenting interventions in progress notes to demonstrate medical necessity. LCBHS will provide quarterly training to clinical staff on this standard. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide quarterly training to clinical staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.1.1.3b1
The interventions documented on the progress notes for the following Line numbers did not meet medical necessity since the service provided did not specifically address the mental health condition or impairment identified in the assessment, and was solely Transportation**:**

- **Line numbers 6 and 9**. **RR11e, refer to Recoupment Summary for details.**

Requirement

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

1) Services provided and claimed are not solely transportation, clerical, or payee related.
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, sections 1810.247, 1810.345(a), 1810.335(a)(2), 1830.205(b)(3), and MHSUDS IN. NO. 20-061, Enclosure 4.

Corrective Action Description
Policy #146 (Progress Notes) will be updated to clarify standards around appropriate interventions that meet medical necessity criteria and accurately documenting interventions in progress notes to demonstrate medical necessity. LCBHS will provide quarterly training to clinical staff on this standard. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee..

Proposed Evidence/Documentation of Correction
Updated policy; evidence of training; chart review results; Compliance Committee minutes.

Ongoing Monitoring (if included)
LCBHS will provide quarterly training to clinical staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized quarterly for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Assessment

Finding 8.2.1

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

1) Two assessments were not completed within the MHP's initial timeliness standard of no more than ten (10) business days after the beneficiary's Episode Opening Date, unless documented otherwise. Specifically:
   - **Line number 1.** The beneficiary's Episode Opening Date was 10/22/2017, while the Initial Assessment was not completed until 11/28/2017, with no documentation of why the completion date was late.

- **Line number 10.** The beneficiary's Episode Opening Date was 9/17/2019, while the Initial Assessment was not completed until 11/14/2019, with no documentation of why the completion date was late.

2) Seven assessments were not completed within the MHP's annual update frequency requirement that was specified on each of the following beneficiaries' Client Plans. Specifically:
   - **Line number 1.** The beneficiary's Assessment was completed on 11/28/2017 with no more recent Assessment submitted by the MHP.
   - **Line number 2.** The beneficiary's prior Assessment was completed on 2/27/2019 with no more recent Assessment submitted by the MHP.
   - **Line number 3.** The beneficiary's prior Assessment was completed on 1/17/2017 while the only other Assessment submitted was a Crisis Assessment completed on 1/7/2020.
   - **Line number 4.** The beneficiary's prior Assessment was completed on 1/26/2018, with no more recent Assessment submitted by the MHP.
   - **Line number 5.** The beneficiary's prior Assessment was completed on 5/1/2017, while the only other Assessment submitted was a Crisis Assessment completed on 3/3/2019.
   - **Line number 6.** The beneficiary's prior Assessment was completed on 4/8/2016, while the current Assessment was not completed until 4/3/2018.
   - **Line number 7.** The beneficiary's prior Assessment was completed on 4/30/2018, while the only other Assessment submitted was a Crisis Assessment completed on 5/10/2019.
   - **Line number 8.** The beneficiary's prior Assessment was completed on 2/6/2019, while the only other Assessment submitted was a CANS Assessment completed on 3/30/2020.

The MHP was given the opportunity to locate additional assessments in question or to provide a written explanation obtained from the medical records of the beneficiaries' indicated above but did not provide that documentation.

Requirement

The MHP shall submit a CAP that:

1) Describes how the MHP will ensure that assessments are completed in accordance with the initial timeliness and update frequency requirements specified in the MHP's written documentation standards.
2) Planned Specialty Mental Health Services are not claimed in the absence of an assessment that substantiates those services.

Corrective Action Description

Policies #103 (Intake Process for Outpatient SMHS) and #142 (Clinical Assessment and Reassessment Standards) will be updated to clarify timeliness standards to ensure timely and accurate intake and assessment. LCBHS will provide quarterly training to relevant staff on intake processes and timelines, and clinical documentation and timeliness standards. Quarterly Access Log and chart reviews will be implemented to

ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide quarterly training to clinical staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.2.2
One or more of the assessments reviewed did not address all of the required elements specified in the MHP Contract. Specifically:

a) Relevant conditions and psychosocial factors affecting the beneficiary's physical health, including living situation, social support, and cultural/linguistic factors: **Line numbers 3 and 7.**
b) Mental Health History, including previous treatment and inpatient admissions: **Line numbers 5, 7 and 8.**
c) Medical History, including significant developmental history: **Line numbers 5, 7 and 8.**
d) Medications, including medication for medical conditions, and documentation of adverse reactions: **Line numbers 7 and 8.**
e) Substance Exposure/Substance Use, including use of tobacco, alcohol, over the counter and illicit drugs: **Line numbers 3, 5 and 7.**
f) Client Strengths: **Line numbers 5 and 7.**
g) Risks: **Line numbers 5 and 7.**
h) A Mental Status Examination: **Line numbers 7 and 8.**

Requirement
The MHP shall submit a CAP that describes how the MHP will ensure that every assessment addresses all of the required elements specified in the MHP Contract with the Department.

Corrective Action Description
Policy #142 (Clinical Assessment and Reassessment Standards) will be updated to clarify the required elements of the assessment, and standards around thorough and accurate documentation. LCBHS will provide quarterly training to clinical staff on these

standards. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide quarterly training to clinical staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies by January 31, 2023; submit additional evidence by April 30, 2023

Medication Consent

Finding 8.3.1

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 1**: There was no written medication consent form found in the medical record. *During the review, MHP staff was given the opportunity to locate the missing medication consent form but was unable to locate it in the medical record.*
2) **Line numbers 1, 3 and 7**: Although there was a written medication consent form in the medical record, there was no medication consent for each and every medication prescribed during the chart review period. *The MHP was given the opportunity to locate the medication consent(s) in question but was unable to locate it/them in the medical record.*

Requirement
The MHP shall submit a CAP 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.

Corrective Action Description
Policy #110 (Consent for Services and Consent for Treatment with Medications) and the LCBHS Consent for Medications form will be updated to include all of the required elements, and ensure that clients consent to each and every medication prescribed. LCBHS will provide annual training to medical and medication support staff on thorough and accurate consent documentation. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized quarterly for the QIC.
Proposed Evidence/Documentation of Correction
Updated policy and form; evidence of training; chart review results; QIC minutes

Ongoing Monitoring (if included)
LCBHS will provide annual training to medical and medication support staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy and form by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.3.2

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:

1) Duration of taking the medication: **Line number 2.**
2) Possible side effects if taken longer than 3 months: **Line number 2.**
3) Consent once given may be withdrawn at any time: **Line number 2.**

Requirement
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
Policy #110 (Consent for Services and Consent for Treatment with Medications) and the LCBHS Consent for Medications form will be updated to include all of the required elements. LCBHS will provide annual training to medical and medication support staff on thorough and accurate consent documentation. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized quarterly for the QIC.

Proposed Evidence/Documentation of Correction
Updated policy and form; evidence of training; chart review results; QIC minutes

Ongoing Monitoring (if included)
LCBHS will provide annual training to medical and medication support staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy and form by January 31, 2023; submit additional evidence by April 30, 2023

Client Plans

Finding 8.4.3

One Client Plan was 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). Specifically:

- **Line number 10**: The Initial Client Plan was not completed until after one or more planned service was provided and claimed. **RR4a, refer to Recoupment Summary for details.**

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

1) Client plans are completed prior to the provision of planned services.
2) Planned services are not claimed when the service provided is not included on a current Client Plan.

Corrective Action Description
Policies #143 (Client Treatment Plans) and #104 (Authorization Process for Outpatient SMHS) will be updated to clarify timeliness and content standards of client treatment plans. LCBHS will provide quarterly training to service delivery staff on these standards. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)

LCBHS will provide quarterly training to service delivery staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.4.3a
Three client plans were not updated at least annually. Specifically:

- **Line number 3**: There was a **lapse** between the prior and current Client Plans and, therefore, no client plan was in effect during a portion or all of the audit review period. **RR4b, refer to Recoupment Summary for details.**
- **Line number 7**: There was a **lapse** between the prior and current Client Plans. **However**, this occurred outside of the audit review period. Prior Client Plan expired on 6/13/2019; current Client Plan completed on 11/6/2019.
- **Line number 6**: There was a **lapse** between the prior and current Client Plans. However, there were no claims during this period. Prior Client Plan expired on 1/2/2020; current Client Plan completed on 1/29/2020.

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

1) Client plans are completed prior to the provision of planned services.
2) Client plans are updated at least on an annual basis, as required by the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.

Corrective Action Description
Policy #143 (Client Treatment Plans) will be updated to clarify timeliness and content standards of client treatment plans. LCBHS will provide quarterly training to service delivery staff on these standards. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide annual training to service delivery staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)

Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.4.11

Line numbers 8: There was no documentation on the current Client Plan that the beneficiary or legal guardian was offered a copy of the Client Plan. Specifically:

- **Line number 8.** Plans completed on 2/22/2019 and 2/12/2020.

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

1) Ensure that there is documentation on the Client Plan substantiating that the beneficiary was offered a copy of the Client Plan.
2) Submit evidence that the MHP has an established process to document that each beneficiary is offered a copy of their current Client Plan.

Corrective Action Description
Policy #143 (Client Treatment Plans) will be updated to clarify signature standards of client treatment plans. LCBHS will provide annual training to service delivery staff on these standards. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide quarterly training to service delivery staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.
Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Progress Notes

Finding 8.5.2

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 2, 3, 4, 5, 6, 7, 8, 9 and 10.** One or more progress note was not completed within the MHP's written timeliness standard of five (5) business days after provision of service. Twenty Six (14 percent) of all progress notes reviewed were completed late (86% compliance).
- **Line numbers 6 and 9.** Eight (4 percent) of all progress notes reviewed contained the exact same verbiage, and therefore those progress notes were not individualized in terms of the specific interventions applied, as specified in the MHP Contract with the Department (96% compliance):
    - Line number 6:
        - Service Function Code 1 Service Date 2/12/2020 Time 125 min
        - Service Function Code 1 Service Date 2/20/2020 Time 70 min
        - Service Function Code 1 Service Date 3/5/2020 Time 150 min
    - Line number 9:
        - Service Function Code 1 Service Date 2/5/2020 Time 130 min
        - Service Function Code 1 Service Date 2/19/2020 Time 105 min
        - Service Function Code 1 Service Date 2/26/2020 Time 75 min
        - Service Function Code 1 Service Date 3/4/2020 Time 190 min
        - Service Function Code 1 Service Date 3/11/2020 Time 190 min

Requirement

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

1) 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.
2) Progress notes contain documentation that is individualized for each service provided.
3) Specialty Mental Health Services claimed are accurate and are actually provided to the beneficiary.

Corrective Action Description

Policy #146 (Progress Notes) will be updated to clarify timeliness and content standards of progress notes. LCBHS will provide annual training to service delivery staff on progress note standards, including individualization of interventions. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction

Updated policy; evidence of training; chart review results; QIC minutes

Ongoing Monitoring (if included)

LCBHS will provide annual training to service delivery staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)

Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.5.3
Documentation of services provided to, or on behalf of, a beneficiary by one or more persons at one point in time did not include all required components. Specifically:

- **Line numbers 3 and 5.** While the MHP was able to provide separate documentation listing the number of participants in each group, nine (5 percent) of all group progress notes reviewed did not accurately document the number of participants in the group; e.g., on the progress note participants were recorded as "1." (95% compliance).

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

1) Contain the actual number of clients participating in a group activity, the number and identification of all group provider/facilitators, the correct type of service (e.g., Group Rehabilitation or Group Psychotherapy), and date of service.
2) Contain accurate and complete documentation of claimed service activities, that the documentation is consistent with services claimed, and that services are not claimed when billing criteria are not met.
3) Include a clinical rationale when more than one (1) provider renders services within the same group session or activity.

Corrective Action Description
Policy #146 (Progress Notes) will be updated to clarify timeliness and content standards of progress notes, including group notes. LCBHS will provide annual training to service delivery staff on these standards. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide quarterly training to service delivery staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.5.4
Progress notes were not documented according to the contractual requirements specified in the MHP Contract. Specifically:

- **Line number 9**: 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. Specifically:
    - Progress Note Service Date 2/5/2020, Time 45 min. Claimed as Plan Development but note content documented a Collateral service.
    - Progress Note Service Date 2/19/2020, Time 73 min. Claimed as Plan Development but note content documented an Individual Therapy session.
    - Progress Note Service Date 3/4/2020, Time 74 min. Claimed as Plan Development but note content documented an Individual Therapy session.
    - Progress Note Service Date 3/10/2020, Time 60 min. Claimed as Plan Development but note content documented a Collateral "Supportive" and "Psychoeducation" session.
    - Progress Note Service Date 3/17/2020, Time 33 min. Claimed as Plan Development but note content documented a Collateral service.
    - Progress Note Service Date 3/25/2020 Time 77 min. Claimed as Plan Development but note content documented a Collateral service.

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

1) Ensure that all Specialty Mental Health Services claimed are 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.

Corrective Action Description
Policy #146 (Progress Notes) will be updated to clarify content standards of progress notes, including accurate service descriptions. LCBHS will provide annual training to service delivery staff on these standards. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide annual training to service delivery staff and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Provision of ICC Services and IHBS for Children and Youth

Finding 8.6.1

1) The MHP did not furnish evidence that it has a standard procedure for providing and 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 records 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 in their Client Plan: **Line numbers 6, 7 and 10.**

Requirement
The MHP shall submit a CAP that describes how it will ensure that:
1) Written documentation is in place describing the process for determining and documenting eligibility and need for ICC Services and IHBS.
2) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC and IBHS.
3) Each beneficiary under age 22 who is authorized to receive Specialty Mental Health Services also receives an individualized determination of eligibility and need for ICC Service and IHBS prior to or during the development of the beneficiary's Initial Client Plan.

Corrective Action Description
Policies #142 (Clinical Assessment and Reassessment Standards) and #108 (Pathways to Wellbeing/Intensive Services for Youth) will be updated to include the standards for assessing children/youth for ICC and IHBS services. LCBHS will provide annual training to clinical staff on these standards. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction

Updated policies; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide annual training to clinical staff, and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies by January 31, 2023; submit additional evidence by April 30, 2023

Finding 8.6.2

1) 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.
2) The medical record for the following beneficiary who received one or more ICC service did not contain evidence that the MHP had reassessed the strengths and needs of the beneficiary, at least every 90 days, for the purpose of determining if those services should be modified: **Line number 9.**
3) The medical record for the following beneficiary whose current Client Plan included he provision of ICC services contained no evidence that those services were actually provided during the chart review period. Nor did the medical record for this beneficiary contain evidence that the MHP had reassessed the strengths and needs of the beneficiary, at least every 90 days, for the purpose of determining if ICC services should be modified: **Line number 8.**

Requirement
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

Policy #108 (Pathways to Wellbeing/Intensive Services for Youth) will be updated to include the 90-day review standard for children/youth receiving ICC services. LCBHS will provide annual training to clinical staff on this standard. Quarterly chart reviews will be implemented to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy; evidence of training; chart review results; Compliance Committee minutes

Ongoing Monitoring (if included)
LCBHS will provide annual training to clinical staff, and will conduct quarterly peer/QI chart reviews to ensure compliance. Activities and findings will be summarized semi-annually for the Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies by January 31, 2023; submit additional evidence by April 30, 2023