DEPARTMENT OF HEALTH CARE SERVICES
REVIEW OF NAPA COUNTY MENTAL HEALTH PLAN
NOVEMBER 5 & 6, 2018
CHART REVIEW FINDINGS REPORT

Chart Review – Non-Hospital Services

The medical records of five (5) adult and five (5) 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 Napa 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__185__claims submitted for the months of January, February and March of **2018**.

Contents

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) 1) 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. (MHP Contract, Ex. A, Att 2) 2) The MHP shall ensure that all medically necessary SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. (MHP Contract, Ex. A, Att 2)

FINDINGS:

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. According to the MHP standards, "re-assessments are due annually (every 3 years for Med Clinic only clients)." The following are specific findings from the chart sample:

- **Line number [1]**: The updated assessment was completed late. The updated assessment was completed on [2]. The prior assessment was completed on [3], and consisted of just a diagnosis page. According to the MHP, the beneficiary was a "med clinic" only client prior to [4] and required an assessment every 3 years. At the onsite review, the chart lead requested the previous assessment but the MHP could not locate that assessment.
- **Line number [5]**: For tracking timeliness of updated assessments, there is no clear definition of "medication only" clients and no clear documentation in the record when a beneficiary's "medication only" services begin and end.

2) Assessments for "meds only" clients are updated every three years based on MHP Policy. Many have chronic conditions and receive medication only services. Based on the current assessment frequency, determination of services provided in sufficient amount, duration, and scope cannot be made.

PLAN OF CORRECTION:

The MHP shall submit a POC that:

1) Provides evidence that the MHP has written documentation standards for assessments, including required elements or timeliness and frequency as required in the MHP Contract with the Department.
2) 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.
3) Provide a clear definition of "Med Clinic only" and document when the beneficiary's "medication only" services begin and end.
4) Describe how the MHP will ensure that services are provided in sufficient amount, duration, and scope.

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

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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;

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:

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:

a) Medications: **Line numbers [6].**
b) A mental status examination: **Line number [7].**
c) A full diagnosis from the current ICD code: **Line number [8].**

PLAN OF CORRECTION:

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.

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

FINDINGS:
Assessment(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:

- The type of professional degree, licensure, or job title of person providing the service:
  - **Line number [9].**

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

1) The signature of the person (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

REQUIREMENTS
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)

FINDINGS:
Documentation in the medical record did not meet the following requirements:

- The assessment was not signed by a provider whose scope of practice includes the provision of the service documented on the assessment; i.e., the provider's scope of practice did not include conducting a mental status exam: **Line number [10].**

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

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1) 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.
2) Staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.
3) All claims for services delivered by any person who was not qualified to provide are disallowed.

Medication Consent

REQUIREMENTS
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)

FINDINGS:

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 [11]**: 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 number [12]**: The written medication consent form was not signed by the beneficiary.

PLAN OF CORRECTION:

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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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.* 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)

FINDINGS:

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** [13]: The medical record indicated an acute change in the beneficiary's mental health status (e.g. multiple crisis interventions, recent medication changes, "excessive anxiety and panic for the last two months" in [14]). However, no evidence was found in the medical record that the client plan was reviewed to determine if the plan continued to be appropriate and/or updated in response to the recent decline.

PLAN OF CORRECTION:

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

1) Ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

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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)

FINDINGS:

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 numbers [15].**
- One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan. **Line numbers [16].**
- One or more of the proposed interventions did not indicate an expected duration. **Line numbers [17].**
- One or more client plans did not address the mental health needs and functional impairments identified as a result of the mental disorder. **Line numbers [18].**

PLAN OF CORRECTION:

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 of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).
3) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

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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.

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 or the signature of 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).) The MHP shall have a written definition of what constitutes a long-term care beneficiary. (MHP Contract, Ex. A, Att. 9)

FINDINGS:

There is no documentation that the beneficiary is participating in and agreeing with the client plan.

- **Line [19]:** The beneficiary is signing a printed copy of the treatment plan that is not clear. The plan contains multiple interventions that were used historically without a clear distinction between the current and historical interventions. In addition, there is no description of the interventions in order to make an informed decision.
- **Line [20]:** The beneficiary is signing two client plans from different providers and one provider's plan still contains interventions that it no longer provides directly. From a beneficiary's perspective this would be confusing.

PLAN OF CORRECTION:

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

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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).

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; 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)

FINDINGS:

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 [21].**
- Progress notes did not document beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions. The exact same verbiage was recorded on multiple progress notes, and therefore those progress notes were not individualized. **Line numbers [22].**

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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.

RR14. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

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)

FINDINGS:

- The amount of time taken to provide services. There were progress notes in the medical record for the dates of service claimed. However, the amount of time documented on the progress note to provide the service was less than the time claimed. **Line numbers [23].**
  RR8b3, refer to Recoupment Summary for details.
- Appointment was missed or cancelled. **Line number [24]. RR15a, refer to Recoupment Summary for details.**

PLAN OF CORRECTION:

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.
   - Beneficiary encounters, including relevant clinical decisions, when decisions are made, and alternative approaches for future interventions, as specified in the MHP Contract with the Department.

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- The claim must accurately reflect the amount of time taken to provide services.

2) Documentation is individualized for each service provided.

REQUIREMENTS
Claims for ICC must use the following: 1) Procedure code T1017 2) Procedure modifier "HK" 3) Mode of service 15 4) Service function code 07 (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

FINDINGS:

- One claim was submitted for Targeted Case Management (Service Function "01") but the progress note associated with the date and time claimed indicated that the service provided was actually for participation in a CFT meeting, or for providing another ICC-specific service activity, and should have been claimed as an ICC case management service (Service Function code 07). **Line [25].**

PLAN OF CORRECTION:

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

1) The service activity described in the body of all progress notes is consistent with the specific service activity claimed - i.e., all claims submitted must be accurate and consistent with the actual service provided in terms of type of service, date of service and time of service.

REQUIREMENTS
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 Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

FINDINGS:

- The MHP did not furnish evidence that it has a standard procedure for providing individualized determinations of eligibility for ICC and IHBS services for beneficiaries 0-20 years of age that is based on their strengths and needs.
- The medical record associated with the following Line number(s) did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS:

[25] Line number(s) removed for confidentiality

- **Line [26]:** Beneficiary is in special education and recently hospitalized but no documentation that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS
- **Line [27]:** Beneficiary is involved with two child-serving systems (Mental Health and Child Welfare) but no documentation that the beneficiary received an individualized determination of eligibility and need for ICC and IHBS.

PLAN OF CORRECTION:

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

1) Written documentation is in place describing the process for determining and documenting the eligibility and need for ICC and IHBS.
2) Training is provided to all staff and contracted providers who have the responsibility for determining the eligibility and need for the provision of ICC and IBHS.
3) Each beneficiary under the age of 22 who is authorized to receive Specialty Mental Health Services (SMHS) also receives an individualized determination of eligibility and need for ICC and IHBS prior to or during the development of the beneficiary's Initial Client Plan.

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