DEPARTMENT OF HEALTH CARE SERVICES
REVIEW OF ALPINE COUNTY MENTAL HEALTH PLAN
May 6-7, 2019
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 Sonoma County Mental Health Plan (MHP) and the California Department of Health Care Services (DHCS); and for consistency with the MHP's own documentation standards and policies and procedures regarding medical records documentation. The process included a review of **104** 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)

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

Two assessments were not completed within the ***annual*** update frequency specified in the MHP's written documentation standards. The following are specific findings from the chart sample:

- **Line number [1]**: The prior assessment was completed on [2] while the subsequent assessment was completed on [3].
- **Line number [4]**: The prior assessment was completed on [5] while the subsequent assessment was completed on [6].

PLAN OF CORRECTION 2A:
The MHP shall submit a POC that 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.

REQUIREMENTS

[1] Line number(s) removed for confidentiality
[2] Date(s) removed for confidentiality
[3] Date(s) removed for confidentiality
[4] Line number(s) removed for confidentiality
[5] Date(s) removed for confidentiality
[6] Date(s) removed for confidentiality

The MHP shall ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed:

a) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;
b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
c) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
d) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
e) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
g) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
h) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
i) A mental status examination;
j) A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,
k) Additional clarifying formulation information, as needed.

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

FINDINGS 2B:

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

d) Medical History.

Line number [7]: Medical History was missing from the assessment that was in effect during the review period.

h) Risks.

Line numbers [8]: Risks the beneficiary presents that are likely to affect the course of treatment should be more clearly identified as part of each assessment.

j) A full diagnosis from the current ICD code using criteria obtained from the current DSM.

Line number [9]: Although the assessment included the eligible diagnosis of "Residual Schizophrenia", this diagnosis was not consistent with the presence of active "delusions" and "auditory hallucinations" that was determined from the Mental Status Exam findings recorded as part of the same assessment.

PLAN OF CORRECTION 2B:

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.
(in subsequent discussion, the MHP indicated it has already begun to address this POC)

Medication Consent

The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. (MHP Contract, Ex. A., Att.9)

FINDING 3A:

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of every prescribed psychiatric medication:

Line number [10]:
Although there was a written Medication Consent form in the medical record, there was no Medication Consent for two (2) of the medications prescribed to the beneficiary. *During the on-site review, the MHP staff were given the opportunity to locate the missing medication consent forms.*

[7] Line number(s) removed for confidentiality
[8] Line number(s) removed for confidentiality
[9] Line number(s) removed for confidentiality
[10] Line number(s) removed for confidentiality

PLAN OF CORRECTION 3A:

The MHP shall submit a POC to address actions it will implement to ensure the following:

1) A written medication consent form is obtained and retained for each and every 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.

REQUIREMENTS
Medication consent for psychiatric medications shall include the following required elements: 1) The reasons for taking such medications. 2) Reasonable alternative treatments available, if any. 3) Type of medication. 4) Range of frequency (of administration). 5) Dosage. 6) Method of administration. 7) Duration of taking the medication. 8) Probable side effects. 9) Possible side effects if taken longer than 3 months. 10) Consent once given may be withdrawn at any time. (MHP Contract, Ex. A, Attachment 9)

FINDING 3B:

Written Medication Consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented on the medication consent form, and/or documented to have been reviewed with the beneficiary:

2) Reasonable alternative treatments available, if any: **Line numbers [11].**

7) Duration of taking each medication: **Line numbers [12].**

8) Probable side effects: **Line number [13].**

9) Possible side effects if taken longer than 3 months: **Line numbers [14].**

10) Consent once given may be withdrawn *at any time*: **Line numbers [15].**

PLAN OF CORRECTION 3B:

[11] Line number(s) removed for confidentiality
[12] Line number(s) removed for confidentiality
[13] Line number(s) removed for confidentiality
[14] Line number(s) removed for confidentiality
[15] Line number(s) removed for confidentiality

The MHP shall submit a POC that describes how the MHP will ensure that every Medication Consent form and completion process addresses all of the required elements specified in the MHP Contract with the Department

(in subsequent discussion, the MHP indicated it has already begun to address this POC)

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)

Finding 3C:
Medication Consents in the chart sample did not include the signature of the person providing the service that includes the person's professional degree, licensure or job title. Below are the specific findings pertaining to the charts in the review sample:

- Missing professional degree, licensure, or job title of person providing the service:
  - **Line numbers** [16] (signature with title/licensure not legible).

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

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

2) Date the signature was completed and the document was entered into the medical record.

(in subsequent discussion, the MHP indicated it has already begun to address this POC)

REQUIREMENTS

[16] Line number(s) removed for confidentiality

The MHP shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be:

1) Under the supervision of a person licensed to prescribe or dispense medication.
2) Performed at least annually.
3) Inclusive of medications prescribed to adults and youth.

(MHP Contract, Ex.A, Att.5)

FINDING 3D:
The MHP did not furnish evidence that it has an ongoing mechanism for monitoring and ensuring the safety and effectiveness of its Telepsychiatry medication practices.

PLAN OF CORRECTION 3D:
The MHP shall submit a POC that describes how the MHP will ensure that mechanisms are in place for monitoring and assessing the safety and effectiveness of the MHP's Telepsychiatry medication practices, are under the supervision of qualified staff, are performed at least annually, and pertain to all beneficiary age groups (i.e., children, adolescents, adults and seniors).

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)

FINDING 4A:

Client plans were not completed prior to the delivery of planned services and/or were not updated at least annually or reviewed and updated when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department). Below are the specific findings pertaining to the charts in the review sample:

- **Line numbers [17]:** The initial client plan was not completed until after treatment services were claimed. **RR4a, refer to Recoupment Summary for details.**
- **Line number [18]**: There was a **lapse** between the prior and current client plans. However, this occurred outside of the audit review period (i.e., the prior plan was signed [19] while the subsequent plan was signed on [20]).
- **Line numbers [21]**: The medical record indicated an acute change in the beneficiary's mental health status (e.g. hospitalized, suicide attempt, multiple crisis intervention encounters. However, no evidence was found in the medical record that the client plan was reviewed and/or updated in response to the change described as folllows:
  - **Line number [22]:** A housing crisis occurred that affected the beneficiary's mental health status with services focused on this issue, but no formal review or update of the client plan was found in the medical record.
  - **Line number [23]:** The physician providing medication support services recorded a change in the beneficiary's behavior and mental health status. However, no evidence was found in the medical record of a review/update of the client plan, or of coordination/communication regarding this issue between the physician and the beneficiary's other Specialty Mental Health providers.

PLAN OF CORRECTION 4A:

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

1) Client plans are completed prior to planned services being provided.

[17] Line number(s) removed for confidentiality
[18] Line number(s) removed for confidentiality
[19] Date(s) removed for confidentiality
[20] Date(s) removed for confidentiality
[21] Line number(s) removed for confidentiality
[22] Line number(s) removed for confidentiality
[23] Line number(s) removed for confidentiality

2) Client plans are updated at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.
3) Planned services are not claimed when the service provided is not included on the current client plan.
4) Client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

(in subsequent discussion, the MHP indicated it has already begun to address this POC)

REQUIREMENTS
The MHP shall ensure that Client Plans: a) Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis. b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided. c) Have a proposed frequency of intervention(s). d) Have a proposed duration of intervention(s). e) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b). f) Have interventions that are consistent with the client plan goals. g) Be consistent with the qualifying diagnoses. (MHP Contract, Ex. A, Attachment 9)

FINDING 4C:
Client plans did not include all of the required elements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

- One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis: **Line numbers [24].**
- One client plan did not include any information that would allow the reader to obtain an expected duration for each proposed intervention: **Line number [25].**

  Note. *While it is possible to **calculate** an expected duration for each proposed intervention **indirectly** from the data contained on client plans for the remaining Line #s, duration is not directly displayed on these documents. In addition, while the MHP's Client Plan format or template includes a column labeled, "Target Date" (i.e., expected duration), this column was left blank for all Client Plans reviewed in the sample.*

PLAN OF CORRECTION 4C:

[24] Line number(s) removed for confidentiality
[25] Line number(s) removed for confidentiality

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

1) 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 proposed on the MHP's Client Plans clearly indicate both an expected frequency and duration for each intervention.
3) The "Target Date" column on the MHP's Client Plans contains an expected duration for each proposed intervention.

(in subsequent discussion, the MHP indicated it has already begun to address this POC)

Progress Notes

REQUIREMENTS
The MHP shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include: a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity; b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions; c) Interventions applied, beneficiary's response to the interventions and the location of the interventions; d) The date the services were provided; e) Documentation of referrals to community resources and other agencies, when appropriate; f) Documentation of follow-up care, or as appropriate, a discharge summary; and g) The amount of time taken to provide services; and h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title. (MHP Contract, Ex. A, Attachment 9)

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

RR15. The MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:

a) No show / appointment cancelled, and no other eligible service documented (e.g., chart review to prepare for an appointment that turns out to be a "no show"), or

b) Service provided did not meet the applicable definition of a SMHS.

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

FINDING 5B:

Progress notes did not include timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity, as required in the MHP Contract. One or more progress notes was not completed within the timeliness and/or frequency standards in accordance with the MHP Contract and the MHP's written documentation standards. Below are the specific findings pertaining to the charts in the review sample:

- Eighteen progress notes associated with the following line numbers 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 [26].**
- Appointment was missed or cancelled: **Line number [27]. RR15a, refer to Recoupment Summary for details.**
- The exact same verbiage was recorded on multiple progress notes for two beneficiaries, and therefore those progress notes were not individualized, as specified in the MHP Contract with the Department for: **Line numbers [28] (dated [29])**

PLAN OF CORRECTION 5B:

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

1) 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.
2) Documentation is individualized for each service provided.

[26] Line number(s) removed for confidentiality
[27] Line number(s) removed for confidentiality
[28] Line number(s) removed for confidentiality
[29] Date(s) removed for confidentiality

3) Specialty Mental Health Services claimed are actually provided to the beneficiary.

REQUIREMENTS
When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include: 1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary. 2) The exact number of minutes used by persons providing the service. 3) Signature(s) of person(s) providing the services. (CCR, title 9, § 1840.314(c).)

FINDING 5C:
Documentation of services being provided to, or on behalf of, two or more beneficiaries at one point in time did not include all required components. Specifically:

- **Line number [30]**: Progress notes did not accurately document the actual number of group participants served.

PLAN OF CORRECTION 5C:
The MHP shall submit a POC that describes how the MHP will ensure that the number of clients in the group, number and identity of staff, units of time, type of service and dates of service documented on group progress notes are accurate and consistent with their associated claims and other documentation in the medical record.

REQUIREMENTS
Progress notes shall be documented at the frequency by type of service indicated below: a) Every Service Contact: i. Mental Health Services; ii. Medication Support Services; iii. Crisis Intervention; iv. Targeted Case Management; b) Daily: i. Crisis Residential; ii. Crisis Stabilization (1x/23hr);

[30] Line number(s) removed for confidentiality

iii. Day Treatment Intensive;

c) Weekly:
   i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;
   ii. Day Rehabilitation;
   iii. Adult Residential.

(MHP Contract, Ex. A, Attachment 9)

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

RR8. The MHP did not submit a progress note corresponding to the claim submitted to DHCS for reimbursement, as follows:

a) No progress note submitted

b) The progress note provided by the MHP does not match the claim submitted to DHCS for reimbursement in terms of the following:
   1) Specialty Mental Health Service claimed.
   2) Date of service, and/or
   3) Units of time.

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

FINDING 5D:
Progress notes were not documented according to the requirements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

- **Line number [31]**: The type of Specialty Mental Health Service (SMHS) (e.g., Medication Support, Targeted Case Management) documented on the progress note was not consistent with the type of SMHS claimed. **RR8b1, refer to Recoupment Summary for details.**
- **Line numbers [32]**: The service activity identified on the Progress Note (e.g., Assessment vs Plan Development vs Collateral vs Rehabilitation vs Psychotherapy, or Targeted Case Management vs ICC services) was not consistent with the specific service activity documented in the body of the progress note, dated as follows:
  - **Line number [33]:** Therapy session documented as Collateral. – [34].
  - **Line number [35]:** ICC team meeting (SF 7) claimed as Case Mgt (SF 01). – [36]

[31] Line number(s) removed for confidentiality
[32] Line number(s) removed for confidentiality
[33] Line number(s) removed for confidentiality
[34] Date(s) removed for confidentiality
[35] Line number(s) removed for confidentiality
[36] Date(s) removed for confidentiality

- **Line number [37]:** Family Therapy documented as Collateral – [38].
- **Line number [39]:** Family Therapy documented as Individual Therapy – [40].
- **Line number [41]:** Family Therapy documented as Collateral – [42]

PLAN OF CORRECTION 5D:
The MHP shall submit a POC that describes how the MHP will:

1) Ensure that all SMHS claimed are:
   a) Documented in the medical record.
   b) Actually provided to the beneficiary.
   c) Claimed for the correct service type, activity, modality billing code, and units of time.
2) Ensure that all progress notes:
   a) Are accurate, complete and meet the documentation requirements described in the MHP Contract with the Department.
   b) Describe the type of service or service activity, the date the service was provided and the amount of time taken to provide the service, as specified in the MHP Contract with the Department.
   c) Document provider participation in ICC "team" meetings, attended by at least one other provider, including documentation of the specific contribution and involvement of each provider whose participation resulted in submission of the claim associated with the note.
   d) Are consistent with the specific service activity claimed.

(in subsequent discussion, the MHP indicated it has already begun to address this POC)

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)

FINDING 6A:

[37] Line number(s) removed for confidentiality
[38] Date(s) removed for confidentiality
[39] Line number(s) removed for confidentiality
[40] Date(s) removed for confidentiality
[41] Line number(s) removed for confidentiality
[42] Date(s) removed for confidentiality

1). The MHP did not furnish evidence that it has a standard procedure for providing individualized determinations of eligibility for ICC services and IHBS for beneficiaries under age 22 years 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 IHBS and/or ICC services:

- **Line numbers [43].**

PLAN OF CORRECTION 6A:*

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

**** In subsequent discussion, the MHP indicated it has already begun to address this POC by: a) adding Service Function code "7" for ICC sessions; b) training staff to determine ICC service needs for all beneficiaries under age 22; c) documenting the determination as part of the "Case Formulation" section of beneficiary Assessments and; d) when appropriate, recording ICC as a proposed intervention on beneficiary client plans***

REQUIREMENTS
The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth, and their families, at least every 90 days, and as needed. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

FINDING 6B:

1) The MHP did not furnish evidence that it has a procedure for reassessing the strengths and needs of children, youth, and their families, at least every 90-days, for the purpose of determining if IHBS and/or ICC services should be added or modified.
2) The medical record for the following Line numbers 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 IBHS and/or ICC services should be added or modified:

[43] Line number(s) removed for confidentiality

- **Line numbers [44].**

PLAN OF CORRECTION 6B:

The MHP shall submit a POC 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 ICC and IHBS at least every 90-days for all beneficiaries receiving SMHS under age 22.
2) Training is provided to all staff and contracted providers who have the responsibility for determining eligibility and need for the provision of ICC and IBHS.
3) Each beneficiary under age 22 who is receiving SMHS also receives a reassment at least every 90-days of eligibility and need for IHBS and ICC services.

[44] Line number(s) removed for confidentiality