San Bernardino County
2015/16 Plan of Correction

P. 6 ITEM #1 SECTION A "Access," Question 9a

9a	Regarding the statewide, 24 hours a day, 7 days per week (24/7) toll free number:
	1) Does the MHP provide a statewide, toll-free telephone number 24 hours a day, seven days per week with language capability in all languages spoken by beneficiaries of the county?
	2) Does the toll-free telephone number provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity PROTOCOL REQUIREMENTS are met?
	3) Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?
	4) Does the toll-free number provide information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing process?
• CCR, title 9, chapter 11, section 1810.405(d) and 1810.410E(1) • CFR, title 42, section 438.406(a)(1) • DMH Information Notice No. 10-02, Enclosure, Page 21, and • DMH Information Notice No. 10-17, Enclosure, Page 16	

Findings:

The DHCS review team made seven test calls to the San Bernardino MHP's 24 hours a day, 7 days a week (24/7) toll-free telephone number prior to review. The MHP was found out of compliance on two out of the seven test calls.

The test call results are as follows:

1) Caller one placed a call in English with the intent of finding mental health services for her minor child. The caller was provided with access to language assistance, information about how to access SMHS and information about services needed to treat a beneficiary's urgent condition. The call was deemed in compliance with the regulatory requirements for protocol questions A9a1, A9a2, and A9a3 (A9a4 n/a).
2) Caller two attempted to make a late-night call to the 24/7 telephone number. This call activated a phone tree whereby the caller was presented with the choice of pressing '1' to wait for an operator or '2' for other options. The caller pressed '1' to talk to a live operator; however, the caller was connected to a voicemail for an MHP clinician instead. When the caller called back to test the second option (by pressing '2'), the caller was connected to the Tax Collector. **This call was deemed Out Of Compliance (OOC) with the regulatory requirements for protocol questions A9a2, A9a3, and A9a4 (A9a1 n/a).**
3) Caller three placed a call in English with the intent of filing a complaint against a therapist. The caller was provided options in other languages by the operator, was provided information to treat a beneficiary's urgent condition, and was provided information about the grievance process. The call was deemed in compliance with the regulatory requirements for protocol questions A9a1, A9a3, and A9a4 (A9a2

n/a).

4) Caller four placed a late-night call in English with the intent of requesting information on mental health services in the County. The caller was provided language options, information about how to access SMHS, as well as information about services needed to treat a beneficiary's urgent condition. The call was deemed in compliance with the regulatory requirements for protocol questions A9a1, A9a2, and A9a3 (A9a4 n/a).
5) Caller five placed a call in English with the intent of seeking a counseling assessment. The caller was provided language options, information about how to access SMHS, including SMHS required to assess whether criteria for medical necessity are met, and the caller was provided information about services needed to treat a beneficiary's urgent condition. The call was deemed in compliance with the regulatory requirements for protocol questions A9a1, A9a2, and A9a3 (A9a4 n/a).
6) Caller six placed a call in English with the intent of accessing services in the County. The caller was provided information about services needed to treat a beneficiary's urgent condition. The call was deemed in compliance with the regulatory requirements for protocol questions A9a1, A9a2, and A9a3 (A9a4 n/a).
7) Caller seven placed a late-night call in English with the intent of seeking services in the County, and indicated that Molina was the current health plan. No assessment was provided for crisis, and even thought the operator provided information on the closest provider site, information on how to access services was suspended once the caller reported the Molina health plan, as the operator assumed that the caller did not qualify for SMHS. **This call was deemed Out Of Compliance (OOC) with the regulatory requirements for protocol questions A9a2 and A9a3 (A9a1 and A9a4 were n/a).**

Plan of Correction

The MHP will provide evidence to DHCS on how it will provide a statewide, toll-free telephone number 24 hours a day, 7 days per week, with language capabilities in all languages spoken by the beneficiaries of the county. All operators available on the 24/7 toll- free telephone number will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing process.

In the previous triennial review of the MHP on March 25-28, 2013, this same protocol item was found to be out of compliance 4 out of 4 times. This is the second triennial review in which this requirement has not been met, although progress has been made

Corrective Action

1) The after-hours (5:00pm – 7:30am) statewide toll-free telephone number protocol will be reviewed for effectiveness over the next six months. As both of the OOC calls resulted from the after-hours protocol, a thorough assessment of the following will be reviewed:
    - Ratio of operators to after-hours callers.
    - After-hours operators' expert knowledge of regulatory requirements

A9a1, A9a2, A9a3, and A9a4.
- All policies and procedures for after-hours 24/7 telephone line, ensuring that all beneficiaries are able to access a live operator at all times.

2) The statewide toll-free telephone number system will be reviewed for technical operational effectiveness, and this action has already begun, with improvements made in collaboration with the County's Information Systems Department. As one of the two OOC call attempts failed, in part, due to the test caller being routed to the County Tax Collector's office, the phone system will undergo a thorough evaluation to ensure that all 24/7 telephone beneficiary callers are connected to a live operator.
3) Quality Management staff will provide regular training for all operators of the statewide toll-free telephone number in order to ensure that all operators are consistently providing telephone service to County beneficiaries that satisfy regulatory requirements A9a1, A9a2, A9a3, and A9a4.
4) Quality Management Staff will conduct and document at minimum two test calls per month to ensure adherence to service protocol for the 24/7 toll-free number, which will serve as evidence of this correction. Corrective feedback will be provided as needed.

P. 7 ITEM #2 SECTION A "Access," Question 10, 10a, and 10b

10	Regarding the written log of initial requests of SMHS:
10a	Does the MHP maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing?
10b	Does the written log(s) of initial log(s) contain:
	1) Name of the beneficiary?
	2) Date of the request?
	3) Initial disposition of the request?
• CCR, title 9, chapter 11, section 1810.405(f)	

Findings:

The MHP did not furnish evidence that its written log(s) of initial requests for SMHS included the required elements of requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: IOM regarding Initial Contact Logs, Initial Contact Log Template, and sample Initial Contact Logs from FY 2012/13, 2013/14, and 2014/15. It was determined that this documentation lacked sufficient evidence of compliance with specific regulatory and/or contractual requirements.

Plan of Correction

The MHP will provide evidence to DHCS on how it will consistently maintain its written log(s) of initial requests made by phone, in person, or in writing. The written log(s) will contain the name of the beneficiary, date of the request, and initial disposition of the request in accordance with regulatory requirements for protocol questions 10, 10a, and 10b.

In the previous triennial review of the MHP in March 25-28, 2013, this same protocol item was found out of compliance. This is the second triennial review in which this regulatory requirement has not been met. Furthermore, the DHCS triennial report does indicate that partial compliance was met with protocol questions A10b1, A10b2, and A10b3, indicating some progress in this area.

Corrective Action

1) Quality Management staff will review the written log(s) over the next six months to ensure that all written log(s) templates are in compliance of regulatory requirements for protocol questions 10, 10a, and 10b.
2) Quality Management staff will provide regular training for all operators of the statewide toll-free telephone number in order to ensure that all operators understand the importance of documenting requests for SMHS that satisfy regulatory requirements 10, 10a, and 10b.
3) Quality Management Staff will conduct and document at minimum two test calls per month an then cross check those calls with the written log(s) to ensure adherence to the regulatory requirements 10, 10a, and 10b, which will serve as evidence of this correction.

P. 3 ITEM #3 SECTION K "Chart Review-Medical Necessity," Question 1, 1a, 1b, 1c, and 1d:

1	Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c below)?
1a	The beneficiary has a current ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract?
1b	The beneficiary, as a result of a mental disorder or emotional disturbance listed in 1a, must have at least one (1) of the following criteria (1-4 below): 1) A significant impairment in an important area of life functioning. 2) A probability of significant deterioration in an important area of life functioning. 3) A probability that the child will not progress developmentally as individually appropriate. 4) For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate.
1c	Do the proposed and actual intervention(s) meet the intervention criteria listed below:
	1) The focus of the proposed and actual interventions(s) is to address the condition identified in No. 1b (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate per 1b(4). 2) The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or D): A. Significantly diminish the impairment. B. Prevent significant deterioration in an important area of life functioning. C. Allow the child to progress developmentally as individually appropriate. D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.
1d	The condition would not be responsive to physical health care base treatment.

- CCR, title 9, chapter 11, section 1830.205(b)(c)
- CCR, title 9, chapter 11, section 1830.210
- CCR, title 9, chapter 11, section 1810.345©
- CCR, title 9, chapter 11, section 1840.112(b)(1-4)
- CCR, title 9, chapter 11, section 1840.314(d)
- CCR, title 22, chapter 3, section 51303(a)
- Credentialing Boards for MH Disciplines

Findings:

1c-1: The medical record associated with the following line number did not meet the medical necessity criteria since the focus of the proposed intervention did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

- **Line number[1]:** Documentation in the medical record does not establish that the focus of the propose intervention is to address the functional impairment identified in CCR, title 9, section 1830.205(b) (2).

Plan of Correction:

1c-1: The MHP shall submit a POC that indicates how the MHP will ensure that intervention are focused on a significant functional impairment that is directly related to the mental health condition as specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

Findings:

1c-2: The medical record associated with the following line numbers did not meet the medical necessity criteria since there was no expectation that the documented intervention would meet the intervention criteria as specified in the CCR, title 9, section 1830.205(b)(3)(B)(1-4).

- **Line numbers[2].** Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:
    a) Significantly diminish the impairment;
    b) Prevent significant deterioration in an important area of life functioning;
    c) Allow the child to progress developmentally as individually appropriate; or
    d) For full- scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

Plan of Correction:

The MHP shall submit a POC that indicates how the MHP will ensure that the interventions provided meet the intervention criteria specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4)

Corrective Action:

1) Quality Management (UR) staff will review and revise the Chart Documentation Training (Medical Necessity Module) with an emphasis as follows:
    a) Interventions focus on a significant functional impairment that is directly related to the mental health condition as specified in CCR, Title 9, Chapter 11, Section 1830.205 (b)(3)(A).
    b) Interventions provided meet the expectation of intervention criteria as specified in CCR, Title 9, chapter 11, section 1830.205 (b)(3)(B)(1-4).
2) Quality Management (UR) staff will review and revise the Chart Documentation Training (Client Plan Module) with an emphasis as follows:
    a) The correct completion of the area of Client Plan that addresses "Observable, measurable, functional impairments related to Diagnostic

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Symptoms."

b) The correct completion of the area of the Client Plan that addresses "Service Coordinator/Provider Interventions" Focus/Purpose.
c) Training and Discussion on how the two sections described above should be inter- related. (See Client Plan- Attachment A)

3) Revised Training Modules will be piloted within our regularly scheduled Chart Documentation trainings and finalized by December 1st, 2017.
4) Effectiveness will be monitored through annual to triennial chart and site reviews and Technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Medical Necessity issues and/or justification of intervention issues. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for Medical Necessity Criteria, and justification for proposed interventions. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of Medical Necessity and justification of provided interventions (overseen by the site's Clinic Supervisor/Program Manager).
5) Chart Documentation Training-(Medical Necessity) will be presented on March 8th, May 4th, July 13th, August 29th, September 7th, and November 2nd, of this calendar year 2017.
6) Chart Documentation Training-(Client Plan) will be presented on March 16th, May 11th, July 20th, August 30th, September 14th, and November 9th, of this calendar year 2017.

P. 3 ITEM #4 SECTION K "Chart Review-Non Hospital Services," Question 4a:

2b	Do the assessments include the areas specified in the MHP contract with the Department? 1) Presenting Problem. The beneficiary's chief complaint, history of presenting problem(s) including current level of functioning, relevant family history, and current family information;
	2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health including, as applicable: living condition,
	3) 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 psychosocial testing or consultation reports
	4) 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.
	5) 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 must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications.
	6) Substance Exposure/Substance Abuse. Past or present use of tobacco, alcohol caffeine, CAM (complementary and alternative medications) and over-the- counter drugs, and illicit drugs;
	7) 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.
	8) Risks. Situations that present a risk to the beneficiary and/or others, including post or current trauma;
	9) A mental status examination;
	10) A complete Diagnosis. A diagnosis from the current ICD-code must be documented. Consistent with the presenting problems, history, mental status examination and/or other clinical data, including any current medical diagnosis.

- CCR, title 9, chapter 11, section 1810.204
- CCR, title 9, chapter 11, section 1840.112(b)(1-4)
- CCR, title 9, chapter 11, section 1840.314(d)(e)
- CCR, title 9, chapter 4, section 851 – Lanterman-Petris-Act
- MH Contract, Exhibit A, Attachment I

Findings:

One or more of the assessments reviewed did not include all of the elements specified in the MHP Contract with the Department. The following required elements were incomplete or missing:

1) Presenting Problem: Line number[3].
2) Mental Health History: Line numbers[4].
3) Medical History: Line numbers[5].
4) Substance Exposure/Substance Use: Line number[6].
5) Client Strengths: Line numbers[7].
6) Risks: Line number[8].
7) A Mental Status Examination: Line numbers[9].

Plan of Correction:

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

Corrective Action:

1) Quality Management (UR) staff will review current DBH Clinical Assessment forms to determine if all required elements, as specified in the MHP contract with the Department, appear and have areas (i.e., fields) to be completed and contain the appropriate prompts to maximize completion.
2) Quality Management (UR) staff will review and revise the Chart Documentation Training by December 1st, 2017 (Clinical Assessment Module) to emphasize:
   a) Completion of all required elements including Presenting Problem, Mental Health History, Medical History, Substance Exposure/Substance Use, Client Strengths, Risks, Mental Status Examination, Relevant conditions and Psychosocial factors, Medications, and complete Diagnosis.
3) Quality Management will construct and distribute a Departmental Information Notice with instructions on the appropriate use of Diagnoses that are to be consistent with

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presenting problems, history, mental status examination, and/or other clinical data, including any current medical diagnosis as present within the Clinical Assessment and/or Psychiatric Evaluation. Quality Management will provide this Information Notice to DHCS by August 1st, 2017.

4) Effectiveness will be monitored through annual to triennial chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Clinical Assessment and/or Diagnostic issues. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for complete Clinical Assessments. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of Complete Initial Assessments and Complete updated Assessments (overseen by the site's Clinic Supervisor/Program Manager).

5) Chart Documentation Training-(Clinical Assessment) will be presented on March 8th, May 4th, July 13th, August 29th, September 7th, and November 2nd, of this calendar year 2017.

P. 4 ITEM #5 SECTION K "Chart Review-Non Hospital Services," Question 3b:

3b	Does The Medication Consent for psychiatric medications include the following required elements: 1) The reasons for taking such medication?
	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?
• CCR, title 9, chapter 11, section 1810.204 • CCR, title 9, chapter 11, section 1840.112(b)(1-4) • CCR, title 9, chapter 11, section 1840.314(d)(e) • CCR, title 9, chapter 4, section 851 – Lanterman-Petris Act • MHP Contract, Exhibit A, Attachment I	

Findings:

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 forms found in the beneficiary's medical record:

1) The reason for taking each medication: **Line numbers[10].**
2) Reasonable alternative treatments available, if any: **Line numbers[11].**
3) Type of medication: **Line numbers[12].**
4) Range of frequency: **Line numbers[13].**
5) Dosage: **Line numbers[14].**
6) Method of administration (oral or injection): **Line numbers[15].**
7) **D**uration of taking each medication: **Line numbers[16].**
8) Probable side effects: **Line numbers[17].**
9) Possible side effects if taken longer than 3 months: **Line numbers[18].**

Plan of Correction:

The MHP shall submit a POC that indicates how the MHP will ensure that every medication consent include documentation of all of the required elements specified in the MHP Contract with the Department.

Corrective Action:

Please note that this finding has been appealed. Corrective action is pending results of this appeal.

1) The current Medication Consent Form will be assessed for the inclusion of each required element per the MHP Contract with the Department.
2) All written medication consents will contain the following documented elements, as required by State and Federal regulations:
   a. The reason for taking each medication
   b. Reasonable alternative treatments available, if any
   c. Type of medication
   d. Range of frequency
   e. Dosage
   f. Method of administration (oral or injection)
   g. Duration of taking each medication
   h. Probable side effects
   i. Possible side effects if taken longer than 3 months
3) The Department of Behavioral Health Outpatient Chart Documentation Manual will be reviewed and updated as needed to ensure complete information

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regarding all of the required elements are included on the written medication consent form.

4) The Quality Management Division will update the Chart Documentation Training Series (Progress Note Module) to include the written medication consent. This training will provide a review of the medication consent and a description of all required elements. The Chart Documentation-(Progress Note) trainings will occur on March 16th, May 11th, July 20th, August 30th, September 14th, and November 9th, of this calendar year 2017.

5) Routine Peer Reviews currently conducted by psychiatrists will incorporate an additional survey of written medication consents to ensure all the required elements are included.

6) Program managers of each program providing medication support services to beneficiaries will ensure monthly audits will include inspection of the written medication consent form completion.

7) Quality Management will construct and distribute a Departmental Information Notice with instructions on the appropriate use of the written medication consents that are to be consistent with all required elements per the MHP contract with the State. Quality Management will provide this Information Notice to DHCS by December 31st, 2017.

8) Effectiveness will be monitored through annual to triennial chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Medication Consent issues. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for complete Medication Consents. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of Complete Medication Consents (overseen by the site's Clinic Supervisor/Program Manager).

P. 4 ITEM #6 SECTION K "Chart Review-Non Hospital Services," Question 4a:

4a	2) Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?
• CCR, title 9, chapter 11, section 1810.205.2 • CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c)(1)(2) • CCR, title 9, chapter 11, section 1840.112(b)(2-5) • CCR, title 9, chapter 11, section 1840.314(d)(e) • DMH Letter 02-01, Enclosure A • WIC section 5751.2 • MHP Contract, Exhibit A, Attachment I • CCR, title 16, section 1820.5 • California Business and Profession Code, section 4999.20	

Findings:

4a-2: The client plan was not updated at least annually or 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):

- **Line number[19]:** There was a lapse between the prior and current client plans and therefore, there was no client plan in effect during a portion or all of the audit review period.
- **Line numbers[20]:** There was a lapse between the prior and current client plans. However, this occurred outside of the audit review period.

Plan of Correction:

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

1. Ensure that client plans are completed at least on an annual basis as required in the MH contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.
2. Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.

Corrective Action:

1) Quality Management (UR) staff will review and revise the Chart Documentation-(Client Plan) training presentation, and will pilot it this year during trainings, with finalization of the training presentation by December 1st 2017, that includes:
   a) Timely completion of initial Client Plans.
   b) Timely completion of updated Client Plans, at a minimum annually.
   c) Other timelines and frequencies as specified in the MHP's Outpatient Chart Documentation manual pertaining to Client Service Plans.
2) Chart Documentation-(Client Plan) trainings will occur March 16, May 11th, July 20th, August 30th, September 14th, and November 9th, of this calendar year 2017.
3) Effectiveness will be monitored through annual to triennial chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Client Plan issues. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for completed Client Plans, which are in compliance with appropriate timelines. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of timely and updated Client Plans (overseen by the site's Clinic Supervisor/Program Manager).

[19] Line numbers removed for confidentiality
[20] Line numbers removed for confidentiality

P. 6 ITEM #7 SECTION K "Chart Review-Non Hospital Services," Question 4b:

4b	Does the client plan include the items specified in the MHP Contract with the Department? 1) 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
	2) The proposed type(s) of the intervention/modality including a detailed description of the intervention to be provided.
	3) The proposed frequency of intervention(s).
	4) The proposed duration of the intervention(s).
	5) Interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.
	6) Interventions are consistent with client plan goal(s) /treatment objective(s).
	7) Be consistent with the qualifying diagnosis.

- CCR, title 9, chapter 11, section 1810.205.2
- CCR, title 9, chapter 11, section 1810.254
- CCR, title 9, chapter 11, section 1810.440(c)(1)(2)
- CCR, title 9, chapter 11, section 1840.112(b)(2-5)
- CCR, title 9, chapter 11, section 1840.314(d)(e)
- DMH Letter 02-01, Enclosure A
- WIC section 5751.2
- MHP Contract, Exhibit A, Attachment I
- CCR, title 16, section 1820.5
- California Business and Profession Code, section 4999.20

Findings:

The following line number(s) had client plan(s) that did not include all of the items specified in the MHP Contract with the Department.

4b-2: 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 (e.g. "medication support services," "targeted case management," "mental health services," etc.). **Line numbers[21].**

4b-3: One or more of the proposed interventions did not indicate an expected frequency. **Line numbers[22].**

Plan of Correction:

[21] Line numbers removed for confidentiality
[22] Line numbers removed for confidentiality

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

1) All mental health intervention/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.).
2) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

Corrective Action:

1) Quality Management (UR) staff will review and revise Current Chart Documentation (Client Plan Module) presentation and pilot the revised presentation over the next six months, to be finalized by December 1st 2017, with emphasis on:
   a) Detailed descriptions of proposed interventions and their duration/frequencies.
   b) Assurance that client plans include interventions that focus on and address the mental health needs and functional impairments of the beneficiary as a result of the mental disorder.
   c) Assurance that interventions on the plan are consistent with the goals and objectives stated on the plan.
2) Chart Documentation Trainings (Client Plan Module) will occur on March 16th, May 11th, July 20th, August 30th, September 14th, and November 9th, of this calendar year 2017, to ensure the orientation of new staff to charting requirements, and as a refresher to existing staff of charting requirements. (See Attachment B)
3) Effectiveness will be monitored through annual to triennial chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Client Plan issues and specifically the appropriate identification and use of interventions that meet Medical Necessity criteria. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for completed Client Plans, and Interventions in compliance with Medical Necessity criteria. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of timely and updated Client Plans (overseen by the site’s Clinic Supervisor/Program Manager).

P. 7 ITEM #8 SECTION K ""Chart Review-Non Hospital Services," Question 4e:

4e	Is there documentation that the contractor offered a copy of the client plan to the beneficiary?

- CCR, title 9, chapter 11, section 1810.254
- CCR, title 9, chapter 11, section 1810.440(c)(1)(2)
- CCR, title 9, chapter 11, section 1840.112(b)(2-5)
- CCR, title 9, chapter 11, section 1840.314(d)(e)
- DMH Letter 02-01, Enclosure A
- WIC section 5751.2
- MHP Contract, Exhibit A, Attachment I
- CCR, title 16, section 1820.5
- California Business and Profession Code, section 4999.20

Findings:

There was no documentation that the beneficiary or legal guardian was offered a copy of the client plan for the following: Line number[23].

Plan of Correction:

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

1) Ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan.
2) Submit evidence that the MHP has an established process to ensure that the beneficiary is offered a copy of the client plan.

Corrective Action:

1) Quality Management (UR) staff will review and revise current Outpatient Chart Documentation Manual and the Chart Documentation (Client Plan Module) presentation over the next six months, to be finalized by December 1st , 2017, with emphasis on:
   a) Assurance that documentation substantiating that the beneficiary was offered a copy of the client plan is present on the client plan.
2) The process to ensure that the beneficiary is offered a copy of the client plan shall be described in detail in the Client Plan section of the Outpatient Chart Manual.
3) Effectiveness will be monitored through annual to triennial, chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Client Plan issues, and specifically the substantiation that the beneficiary was offered a copy of the client plan. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for completed Client Plans, and the substantiation that the beneficiary was offered a copy of the client plan. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of timely

[23] Line numbers removed for confidentiality

and updated Client Plans (overseen by the site's Clinic Supervisor/Program Manager).

P. 8 ITEM #9 SECTION K "Chart Review-Non Hospital Services," Question 4f:

4f	Does the client plan include: 1) The date of service;
	2) The signature of the person providing the service (or electronic equivalent), the person's type of professional degree, and licensure or job title; AND
	3) The date the documentation was entered in the medical record?
• CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c)(1)(2) • CCR, title 9, chapter 11, section 1840.112(b)(2-5) • CCR, title 9, chapter 11, section 1840.314(d)(e) • DMH Letter 02-01, Enclosure A • WIC section 5751.2 • MHP Contract, Exhibit A, Attachment I • CCR, title 16, section 1820.5 • California Business and Profession Code, section 4999.20	

Findings:

The client plan did not include:

1) The signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title. Line number[24].

Plan of Correction:

The MHP shall submit a POC that indicates how the MHP will ensure that all documentation includes the signature (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

Corrective Action:

1) Quality Management (UR) staff will review and revise current Outpatient Chart Documentation Training (Client Plan Module) over the next six months, with emphasis on:
   a) Assurance that the signature of the approved category of staff appears on the Client Plan with professional degree, licensure, or title of the person providing the service.
2) Quality Management (UR) staff will review current Outpatient Chart Manual section regarding correct signature requirements, and revise as necessary by December 1st, 2017.

[24] Line numbers removed for confidentiality

3) Effectiveness will be monitored through annual to triennial, chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Client Plan issues, and specifically the substantiation that the beneficiary was offered a copy of the client plan. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for completed Client Plans, and the substantiation that the beneficiary was offered a copy of the client plan. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of timely and updated Client Plans (overseen by the site's Clinic Supervisor/Program Manager).

P. 9 ITEM #10 SECTION K "Chart Review-Non Hospital Services," Question 5a:

5a	Do the progress notes document the following: 1) Timely documentation (as determined by the MHP) of relevant aspects of client care, including documentation of medical necessity?
	2) Documentation of beneficiary encounters, including relevant clinical decision, 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 signature of the person providing the service (or electronic equivalent), the person's type of professional degree, and licensure or job title?
• CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c) • CCR, title 9, chapter 11, section 1840.112(b)(2-6) • CCR, title 9, chapter 11, section 1840.314 • CCR, title 9, chapter 11, section 1840.316- 1840.322 • CCR, title 22, chapter 3, section 51458.1 • CCR, title 22, chapter 3, section 51470 • MHP Contract, Exhibit A, Attachment I	

Findings:

Progress notes were not completed in accordance with regulatory and contractual requirements and/or with the MHP's own written documentation standards:

One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements.

5a-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 the MHP's written documentation standards.
5a-2) Interventions applied, the beneficiary's response to the interventions and the location of the interventions, as specified in the MHP Contract with the Department.

The MHP was not following its own written documentation standards for timeliness of staff signatures on progress notes.
The progress notes did not document the following:

5a-1) Line numbers[25]: 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).

5a-2) Line number[26]: The intervention applied beneficiary's response to the interventions and the location of the interventions.

5a-3) Line numbers[27]. Timeliness of the progress notes could not be determined because the notes were signed but not dated by the person providing the service. Therefore, the date the progress notes were entered into the medical records could not be determined.

5a-7) Line number[28]: The provider's professional degree, licensure, or job title.

Plan of Correction:

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

1) Ensure that progress notes meet timeliness, frequency and the staff signature requirements in accordance with regulatory and contractual agreements.
2) The MHP shall submit a POC that indicates how the MHP will ensure that progress notes document:

5a-3) The date the progress note was completed and entered into the medical record by the person providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.
5a-2) Interventions applied, the beneficiary's response to the interventions and the location of the interventions, as specified in the MHP Contract with the Department.
5a-3) The date the progress note was completed and entered into the medical record by the person providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.

Findings 5a3:

The following line numbers had documentation indicating a SMHS was provided while the beneficiary resided in a setting that was ineligible for Federal Financial Participation or resided in a setting subject to lockout:

[25] Line numbers removed for confidentiality
[26] Line numbers removed for confidentiality
[27] Line numbers removed for confidentiality
[28] Line numbers removed for confidentiality

- Service was provided to a beneficiary in juvenile hall while the beneficiary was ineligible for Medi-Cal claims. **Line number[29].**

The progress notes for the following line number indicates that the services provided were solely for:

- Clerical. **Line number[30].**

Plan of Correction:

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

1) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning, as outline in the client plan.
2) Services provided and claimed are not solely transportation, clerical, or payee related.
3) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a) (b).
4) Services claimed were provided in a setting where the beneficiary was eligible for FFP or not subject to lockout.

Corrective Action:

1) Quality Management (UR) staff will review and revise the current Chart Documentation Manual and the current Chart Documentation (Progress Note Module) Training over the next six months, to be piloted in trainings (March 16th, May 11th, July 20th, August 30th, September 14th, and November 9th), and with final revisions no later than December 1st, 2017 with an emphasis on written documentation guidelines for:
   a) Timely completion by the service provider of the progress note of the relevant aspects of client care, as specified in the MHP Contract with the Department and the MHP's written documentation standards.
   b) Interventions applied, the beneficiary's response to the interventions and the location of the interventions (included in this will be specific training in regards to "lockout" scenarios) as specified in the MHP Contract with the Department.
   c) The date the progress note was completed and entered into the medical record by the person providing the service, in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.
2) Quality Management (UR) staff will review and revise the current Chart Documentation Manual Section on "Instructions for All Interdisciplinary Notes" over the next six months to address the following:
   a) Inclusion of a description of how services provided reduced the impairment, restored functioning, or prevented significant deterioration in an important area of life functioning, as outlined in the client plan.
   b) Services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments, and are medically necessary as delineated in the CCR, title 9, chapter 11, section 1830.205 (a) (b).

[29] Line numbers removed for confidentiality
[30] Line numbers removed for confidentiality

c) Services provided and claimed are not solely for transportation, clerical, or payee related purposes per DHCS current "Reasons for Recoupment."
d) Services claimed were provided in a setting where the beneficiary was eligible for FFP and not subject to lockout.

3) Effectiveness will be monitored through annual to triennial, chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Progress Note issues as listed above. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for completed Progress Notes, and specifically for each item listed above. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of timely and complete Progress Notes (as overseen by the site's Clinic Supervisor/Program Manager).

P. 10 ITEM #11 SECTION K "Chart Review-Non Hospital Services," Question 5c:

5c	Timeliness/frequency as follows: 1) Every service contract for: A. Mental health services B. Medication support services C. Crisis intervention D. Targeted case management 2) Daily for: A. Crisis residential B. Crisis stabilization (one per 23/hour period) C. Day treatment intensive 3) Weekly for: A. Day treatment intensive B. Day rehabilitation C. Adult residential
• CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c) • CCR, title 9, chapter 11, section 1840.112(b)(2-6) • CCR, title 9, chapter 11, section 1840.314 • CCR, title 9, chapter 11, section 1840.316 – 1840.322 • CCR, title 22, chapter 3, section 51458.1 • CCR, title 22, chapter 3, section 51470 • MHP Contract, Exhibit A, Attachment I	

Findings:

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

- **Line numbers[31].** There were no progress notes in the medical records for

[31] Line numbers removed for confidentiality

the services claimed.

- **Line numbers[32].** The type of SMHS documented in the progress notes were not the same type of SMHS claimed.

Plan of Correction:

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

1) Ensure that all SMHS claimed are:
   a) Documented in the medical record.
   b) Actually provided to the beneficiary.
   c) Appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a) (b).
   d) Claimed for the correct service modality and billing code.
2) Ensure that all progress notes are:
   a. Accurate and meet the documentation requirements described in the MHP Contract with the Department.
   b. Indicate the type of service, 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. Completed within the timeline and frequency specified in the MHP Contract with the Department.

Corrective Action:

1) The MHP will review and revise its policy and procedure for submission of billing to include verification that a service provided was documented and the service time billed is consistent with the service time documented.
2) The MHP will utilize its "Service Verification Procedures" to ensure that services were actually provided to the beneficiary.
3) Quality Management (UR) staff will review and revise Chart Documentation Training (Module on Progress Notes) to be piloted over the next six months in Documentation training (March 16th, May 11th, July 20th, August 30th, September 14th, and November 9th), and finalized by December 1st, 2017, to emphasize the following:
   a) SMHS claimed are appropriate to the qualifying diagnosis, identified functional impairments and meet medical necessity criteria.
   b) Claimed for the correct service modality and billing code.
   c) Indicate the type of service, the date the service was provided and the amount of time taken to provide the service is as specified in the MHP Contract with the Department.
   d) Completed within the timeline and frequency specified in the MHP contract with the Department.
   e) Accurate and meet the documentation requirements described in the MHP contract with the Department.
4) Effectiveness will be monitored through annual to triennial, chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These

[32] Line numbers removed for confidentiality

reviews will entail a full report addressing any Progress Note issues as listed above. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for completed Progress Notes, and specifically for each item listed above. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of timely and complete Progress Notes (as overseen by the site's Clinic Supervisor/Program Manager).

P. 11 ITEM #12 SECTION K "Chart Review-Non Hospital Services," Question 5d:

5d	Do all entries in the beneficiary's medical record include: 1) The date of service? 2) The signature of the person providing the service (or electronic equivalent), the person's type of professional degree, and licensure or job title? 3) The date the documentation was entered in the medical record?
• CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c) • CCR, title 9, chapter 11, section 1840.112(b)(2-6) • CCR, title 9, chapter 11, section 1840.314 • CCR, title 9, chapter 11, section 1840.316 – 1840.322 • CCR, title 22, chapter 3, section 51458.1 • CCR, title 22, chapter 3, section 51470 • MHP Contract, Exhibit A, Attachment I	

Findings:

The progress note did not include:

- One or more progress note for the following line number(s) were signed by another staff member and not by the person providing the service as specified in the MHP Contract with the Department. **Line number[33].**
- Date the documentation was entered in to the medical record. **Line numbers[34].**

Plan of Correction:

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

1) Ensure that all documentation includes the signature (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.
2) Ensure that all documentation includes the date the signature was completed, the date of service and the date the document was entered in to the medical record.
3) Ensure all services are provided by the appropriate and qualified staff within his or her scope of practice, if professional licensure is required for the service.

[33] Line numbers removed for confidentiality
[34] Line numbers removed for confidentiality

4) Ensure that staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.

Corrective Action:

1) MHP will review and revise its policy and procedure in regards to submission of billing to include the verification that documentation includes the signature of the person providing the service.
2) Quality Management (UR) will review and revise its Chart Documentation training (Progress Note module) and pilot it over the next six months (March 16th, May 11th, July 20th, August 30th, September 14th, and November 9th) to include the necessity of date of service, date of signature, and date of entry into the record on all progress notes. Progress Note training module will be finalized based on effectiveness no later than December 1st, 2017.
3) MHP will ensure that once the "EHR" is activated, all progress notes will include date of service, date of signature, and date of entry into the medical record.
4) Quality Management (UR) will review and revise Chart Documentation Manual, section on signature requirements, including appropriate license, discipline, and/or job title in order to ensure and demonstrate scope of practice over the next six months.
5) Effectiveness will be monitored through annual to triennial, chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Progress Note issues as listed above. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for completed Progress Notes, and specifically for each item listed above. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of timely and complete Progress Notes (as overseen by the site's Clinic Supervisor/Program Manager).

P. 11 ITEM #13 SECTION K "Chart Review-Non Hospital Services," Question 7b:

7b	Regarding attendance: 1) Is there documentation of the total number of minutes/hours the beneficiary actually attended the program? 2) If the beneficiary is unavoidably absent: A. Is the total time (number of hours and minutes) the beneficiary actually attended the program that day documented; B. Is the beneficiary present for at least 50 percent of the scheduled hours of operation for that day, AND C. Is there a separate entry in the medical record documenting the reason for the unavoidable absence?
• CCR, title 9, chapter 11, section 1810.212 • CCR, title 9, chapter 11, section 1810.213 • CCR, title 9, chapter 11, section 1840.112(b) • CCR, title 9, chapter 11, section 1840.314(d)(e) • CCR, title 9, chapter 11, section 1840.318 • CCR, title 9, chapter 11, section 1840.360 • MHP Contract, Exhibit A, Attachment I • DMH Letter No. 03-03	

Findings:

Documentation for the following line number indicated that essential requirements for a Day Rehabilitation program was not met, as specified by the MHP Contract with the Department:

- **Line number[35]:** The total number of minutes/hours the beneficiary actually attended the Day Rehabilitation program was not documented.
- **Line number[36]:** The beneficiary was absent and there wasn't a separate entry in the medical record documenting the reason for the unavoidable absence.

Plan of Correction:

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

1) Ensure that the total number of minutes/hours each beneficiary actually attends a Day Rehabilitation program are documented.
2) Ensure that when the beneficiary is unavoidable absent, the total time (number of minutes and hours) the beneficiary actually attended the program that day is

[35] Line numbers removed for confidentiality
[36] Line numbers removed for confidentiality

documented, and the beneficiary is present for 50 percent of the scheduled hours of operation for that day and there is a separate entry in the medical record documenting the reason for the unavoidable absence and provided in order to claim for Day Rehabilitation Program.

Corrective Action:

1) Quality Management (UR) staff will review, revise (if necessary), and re-issue the MHP information notice 14-10 'Guidelines for Day Treatment Intensive and Day Treatment Rehabilitation Programs' for documentation standards for the provision of Day Treatment services (See Attachment C) no later than December 1st 2017, in order to ensure that the total number of minutes/hours each beneficiary actually attends a Day Rehabilitation program are documented.
2) Quality Management (UR) will revise its Scope of Practice Billing Manual, section on Day Rehabilitation, no later than December 1st, 2017, to include instructions to ensure that when the beneficiary is unavoidably absent, the total time (number of minutes and hours) the beneficiary actually attended the program that day is documented, the beneficiary is present for 50 percent of the scheduled hours of operation for that day, and there is a separate entry in the medical record documenting the reason for the unavoidable absence.
3) Quality Management (UR) staff will monitor for the compliance of the above referenced items by the following, through the use of a Day Treatment (Intensive and Rehabilitation) Audit tool that includes all program requirements (i.e.-therapeutic milieu components, community/milieu meeting, required number of hours for groups and therapies, and continuous scheduled hours of operation as more than four (4) hours, etc.):
    a) Effectiveness will be monitored through annual to triennial, chart and site reviews and technical assistance reviews conducted by Quality Management (UR) staff. These reviews will entail a full report addressing any Day Treatment Progress Note issues as listed above. Additionally, internal clinic audits of charts will be performed by clinic staff within the first 90 days of opening a new chart, to review for completed Day Treatment Progress Notes, and specifically for each item listed above. Each month thereafter, a sample of existing charts of ongoing clients will be reviewed for maintenance of timely and complete Progress Notes (as overseen by the site's Clinic Supervisor/Program Manager).