DHCS
JENNIFER KENT
DIRECTOR

StaState of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.

February 24, 2016

FINAL REPORT

Return Receipt Requested

Ms. Dawan Utecht
Fresno County Behavioral Health Services
4441 East Kings Canyon Road
Fresno, CA 93702

Dear Ms. Dawan Utecht:

The Department of Health Care Services (DHCS) Program Oversight and Compliance Branch (POCB) conducted its triennial onsite review of Fresno County's Mental Health Plan (MHP) on May 4-7, 2015. The review team utilized the FY2014/2015 Annual Review Protocol for Consolidated Specialty Mental Health Services and other Funded Services (Mental Health & Substance Use Disorder Services Information Notice No.14-027) to conduct the system and chart review. In accordance with oversight authority contained in the California Code of Regulations, title 9, chapter 11, section 1810.380, POCB reviewed the program and fiscal operations of the MHP to verify that medically necessary services were provided in compliance with State and Federal laws and regulations and/or the terms of the contract between DHCS and the MHP.

This report details the findings of the onsite review. Enclosed are the following:

1. The "FINAL System Review Findings Report" specifies the partial or out of compliance findings, as well as any required Plans of Correction (POC), for all system review items (Sections A-J and the Attestation) in the protocol.
2. The "FINAL Chart Review Findings Report" specifies the out of compliance findings, as well as any required POC, for all chart review items (Section K) in the protocol.
3. The "Recoupment Summary" details the disallowed claims and amounts to be recouped. PLEASE NOTE: As a result of the chart review findings, DHCS is disallowing claims and recouping funds in the amount of **$5,742.90 FFP.**

A POC for all partial or out-of-compliance items will be due sixty (60) days after the final report has been issued. Please do not send a POC until after the issuance of the final report. At that time, the POC should be submitted to:

Autumn Boylan Valerio, MPH
Chief, Compliance Section
Program Oversight and Compliance Branch
Mental Health Services Division
Department of Health Care Services
P.O. Box 997413, MS 2703
Sacramento, CA 95899-7413

Please also send an electronic version of the POC to Autumn Boylan by e-mail to Autumn.Boylan@dhcs.ca.gov.

If the MHP wishes to appeal any of the out-of-compliance findings from the final report, the MHP may do so by submitting an appeal, in writing, within fifteen (15) working days after receipt of the final report. Please address the appeal to the attention of:

John Lessley
Chief, Quality Assurance Section
Program Policy and Quality Assurance Branch
Mental Health Services Division
Department of Health Care Services
P.O. Box 997413, MS 2702
Sacramento, CA 95899-7413

Please also send an electronic version of the appeal to John Lessley by email to John.Lessley@dhcs.ca.gov with a cc: to Autumn Boylan to Autumn.Boylan@dhcs.ca.gov.

If you have any questions regarding this matter, please contact me at (916) 440-7568 or by e-mail to Autumn.Boylan@dhcs.ca.gov.

Sincerely,

Autumn Boylan Valerio, MPH
Chief, Compliance Section
Program Oversight and Compliance Branch
Mental Health Services Division
Department of Health Care Services

cc: Dina Kokkos-Gonzales, Chief, Mental Health Services Division
Lanette Castleman, Chief, Program Oversight and Compliance Branch, Mental Health Services Division
Martine Carlton, Chief, Clinical Review and Chart Audits Section, Program Oversight and Compliance Branch, Mental Health Services Division
John Lessley, Chief, Quality Assurance Section, Program Policy and Quality Assurance Branch, Mental Health Services Division
Shelly Halpain, Administrative Support, Quality Assurance Section, Program Policy and Quality Assurance Branch, Mental Health Services Division

CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES
FISCAL YEAR 2014-2015
FRESNO COUNTY MENTAL HEALTH PLAN REVIEW
MAY 4-7, 2015
FINAL SYSTEM REVIEW FINDINGS REPORT

This report details the findings from the triennial system review of the Fresno County Mental Health Plan (MHP). The report is organized according to the findings from each section of the FY2014/2015 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services (Mental Health and Substance Use Disorder Services Information Notice No. 14-027), specifically Sections A-J and the Attestation. The corresponding protocol language, as well as the regulatory and/or contractual authority, will be followed by the specific findings and required Plan of Correction (POC). Only those items found to be out of compliance (OOC), or deemed in partial compliance, will be detailed in this report; however, the report may include additional information that may be useful for the MHP.

RESULTS SUMMARY: SYSTEM REVIEW

SECTION	SECTION CATEGORY	TOTAL NUMBER OF ITEMS IN SECTION	NUMBER OF ITEMS PARTIAL or OOC	COMPLIANCE PERCENTAGE FOR SECTION
ATTESTATION	MHP ATTESTATION	5	0	100%
SECTION A	ACCESS	43	6	86%
	Requirements OOC or Partial Compliance: 9a2, 9a3, 9a4, 10a, 10b, 10c			
SECTION B	AUTHORIZATION	16	4	75%
	Requirements OOC or Partial Compliance: 1c, 3, 4a, 6c			
SECTION C	BENEFICIARY PROTECTION	21	2	90%
	Requirements OOC or Partial Compliance: 4a, 5a			
SECTION D	FUNDING, REPORTING AND CONTRACTING REQUIREMENTS	3	0	100%
SECTION E	TARGET POPULATIONS AND ARRAY OF SERVICES	3	0	100%
SECTION F	INTERFACE WITH PHYSICAL HEALTH CARE	2	0	100%
SECTION G	PROVIDER RELATIONS	13	1	92%
	Requirements OOC or Partial Compliance: 2			
SECTION H	PROGRAM INTEGRITY	15	0	100%
SECTION I	QUALITY IMPROVEMENT	25	0	100%
SECTION J	MENTAL HEALTH SERVICES ACT	5	0	100%
	TOTAL ITEMS REVIEWED	151	13	91%

ATTESTATION

FINDINGS:
The Department of Health Care Services (DHCS) reviewed Attestation Items 1, 5, 15, 18 and 23. All were found in compliance.

PLAN OF CORRECTION:
None

Section A, "Access," Questions 9a-2, 9a-3, 9a-4:

9. Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:

9a-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 criteria are met?

9a-3. Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?

9a-4. Does the toll-free telephone number provide information to beneficiaries about how to use the beneficiary problem resolution and fair hearing processes?

CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(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
MHP Contract, Exhibit A, Attachment I

The DHCS review team made seven (7) calls to test the MHP's 24/7 toll-free line. The seven (7) test calls are summarized below.

Test call #1 was placed on Sunday, April 5, 2015, at 12:22 pm. The call was initially answered after one (1) ring via recorded message. The recording advised the caller that all lines were busy and if this was an emergency to please hang up and dial 911. After four (4) minutes on hold, a live operator answered the line and advised the caller to hold for an additional three (3) minutes. The caller requested information about mental health services. The operator asked for the caller's name and telephone number. The caller responded to the operator that he/she was unable to provide the requested identifying information and again requested information about mental health services. The operator told the caller to call back during business hours. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met nor was the caller provided with information about services needed to treat an urgent condition. This call was deemed OOC with the regulatory requirements for protocol questions 9a-2 and 9a-3.

Test call #2 was placed on Sunday, May 3, 2015, at 8:30 pm. The call was initially answered after one (1) ring via recorded message. The recording advised the caller that all lines were busy and if this was an emergency to please hang up and dial 911. After a brief wait, a live operator answered the call. The caller requested information about mental health services and was told by the operator that he/she had reached an after-hours emergency line. The operator asked for the caller's name and telephone number and advised the caller that someone would call back within three (3) days. The caller was also told he/she could call back during business hours. The caller inquired if it was necessary to submit personal information as he/she felt

uncomfortable giving personal information. The caller then inquired if there was a walk-in clinic available to obtain services. The operator responded by again asking for the caller's information and reiterated that someone would call him/her back if the information was provided. After asking again about services, the operator provided the caller with the number to Exodus Recovery. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met. After several requests, the caller was eventually provided with information about services needed to treat a beneficiary's urgent condition. This call was deemed OOC with regulatory requirements for protocol questions 9a-2 and 9a-3.

Test call #3 was placed on Thursday, April16, 2015, at 3:21 pm. The call was initially answered after one (1) ring by a live operator. The caller requested information about mental health services. The operator asked for the caller's name and telephone number and advised the caller that someone would return the call within three (3) days. The operator also advised the caller that upon receipt of the caller's personal information that he/she could provide the caller with emergency numbers that the caller could use to contact urgent care providers. The caller provided the operator with the requested personal information and the operator advised the caller how to obtain services from either of the two urgent care wellness centers that are available to provide immediate services. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met. However, after identifying information was provided to the operator, the caller was given information about services needed to treat a beneficiary's urgent condition. This call was deemed OOC with regulatory requirements for protocol question 9a-2 but in compliance with protocol question 9a-3.

Test call #4 was placed on Thursday, April 16, 2015, at 3:10 pm. The call was initially answered immediately via a recorded message indicating that all lines were busy. After being placed on hold for approximately thirty (30) seconds, a live operator answered the phone and inquired if the caller was currently experiencing an emergency situation. After responding in the negative, the caller requested information about mental health services. The operator provided the caller with a telephone number to contact mental health urgent care to obtain immediate services and advised the caller to contact Exodus to initiate SMHS in Fresno County. The caller was provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met and information about services needed to treat a beneficiary's urgent condition. This call was deemed in compliance with regulatory requirements for protocol questions 9a-2 and 9a-3.

Test call #5 was placed on Friday, April 24, 2015, at 7:10 am. The call was initially answered after one (1) ring via recorded message. The recording advised the caller that all lines were busy and to hang up and dial 911 if it was an emergency. The call was then answered by a live operator. The caller requested information about how to access mental health services. The operator advised the caller that he/she had reached the exchange line and offered to have someone call back during business hours. The operator requested personal identifying information from caller and advised that the information will be placed in the system, which would trigger the call back. The caller inquired if there was anyone available immediately and was provided with information about the Wellness Center. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met (i.e., clinic locations and/or hours of operation, etc.); however, the caller was provided with information about services needed to treat a beneficiary's urgent condition. This call was deemed OOC with regulatory requirements for protocol question 9a-2, but in compliance with protocol question 9a-3.

Test call #6 was placed on Thursday, March 19, 2015, at 7:36 am. The call was initially answered after one (1) ring via recorded message. The recording advised the caller that all lines were busy and to hang up and dial 911 if it was an emergency. After being placed on hold for approximately thirty (30) seconds, a live operator answered from the county's answering service. The caller requested information about SMHS. The operator advised the caller that he/she would need to call back during business hours to speak with someone about SMHS. The caller then asked where they should go to obtain services and was provided with contact information and hours of operation for the MHP. The operator advised the caller to provide his/her personal information and someone would call him/her back within three (3) days. The caller was provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met; however, the caller was not provided with information about services needed to treat a beneficiary's urgent condition. This call was deemed in compliance with regulatory requirements for protocol question 9a-2 but OOC with protocol requirements for question 9a-3.

Test call #7 was placed on Friday, April 24, 2015, at 9:22 am. The call was initially answered after two (2) rings via a recorded message. The call was subsequently transferred to a live operator. The operator immediately requested the name and telephone number of the caller advising the caller that someone would call him/her back within three (3) days. The caller asked if there was any place to go to pick up information and/or file a grievance and the operator responded that "I guess you can go to any county to pick it up" and provided the address. The caller was not provided with appropriate information about how to use the beneficiary problem resolution and fair hearing processes. This call was deemed not in compliance with regulatory requirements for protocol question 9a-4.

FINDINGS:

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
9a-1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Not Applicable
9a-2	OOC	OOC	OOC	IN	OOC	IN	n/a	33.3%
9a-3	OOC	OOC	IN	IN	IN	OOC	n/a	50%
9a-4	n/a	n/a	n/a	n/a	n/a	n/a	OOC	0%

PLAN OF CORRECTION:

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a statewide, toll-free telephone number 24 hours a day, 7 days per week, with language capability in all languages spoken by beneficiaries of the county that 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 processes.

Please note: In the previous triennial review, on April 2-5, 2012, this protocol item was found OOC.

Section A, "Access," Questions 10a, 10b, 10c:

10. Regarding the MHP maintaining a written log of initial requests that meets title 9 requirements:

10a. Does the written log contain the name of the beneficiary?

10b. Does the written log contain the date of the request?

10c. Does the written log contain the initial disposition of the request?

CCR, title 9, chapter 11, section 1810.405(f)

FINDING:

The MHP did not provide evidence that its written log(s) of initial requests for SMHS was in compliance with title 9 regulations. Specifically, DHCS found three (3) of the six (6) test calls documented on the written log (with all required elements). The MHP was found in partial compliance (50%) with regulatory requirements for protocol questions 10a, 10b and 10c.

PLAN OF CORRECTION:

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person or in writing) complies with title 9 regulatory requirements.

Please note: In the previous triennial review on April 2-5, 2012, this protocol item was found OOC.

Section B, "Authorization," Question 1c:

1. Regarding the Treatment Authorization Requests (TARs):

1c. Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations?

CCR, title 9, chapter 11, sections 1810.242, 1820.220(c),(d), 1820.220 (f), 1820.220 (h), and 1820.215
CFR, title 42, section 438.210 (d)

FINDING:

The MHP did not provide evidence that it approves or denies all TARs within 14 calendar days of the receipt of the TAR, in accordance with title 9 regulations. Specifically, the DHCS review team found three (3) of the one hundred (100) TARs that were not approved or denied within fourteen (14) calendar days of the receipt of the TAR. The MHP was found in partial compliance (97%) with regulatory requirements for protocol question 1c.

PLAN OF CORRECTION:

The MHP will submit a POC addressing the OOC finding for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it approves or denied TARs within 14 calendar days of receipt of the TAR in accordance with title 9 regulations.

Section B, "Authorization," Question 3:

3. Does the MHP have a payment authorization system in place that meets the requirements regarding Day Treatment Intensive and Day Rehabilitation in accordance with title 9 regulations?

CCR, title 9, chapter 11, sections 1830.215(e) and 1840.318
DMH Information Notice 02-06, Enclosures, Pages 1-5
DMH Letter No. 03-03

FINDING:
The MHP did not furnish evidence it has a payment authorization system in place that meets requirements for Day Treatment Intensive (DTI) and Day Rehabilitation (DR). The MHP's policies and procedures do not specify that providers are required to request advance payment authorization for DTI and DR in advance of service delivery when services will be provided for more than five (5) days per week. The MHP is OOC with the requirements of the MHP contract.

PLAN OF CORRECTION:
The MHP will submit a POC addressing the OOC finding for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has a payment authorization system in place that meets the requirements regarding DTI and DR in accordance with regulatory and MHP contract requirements.

Section B, "Authorization," Question 4a:

4. Regarding authorization timeframes:

4a. For standard authorization decisions, does the MHP make an authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days?

CFR, title 42, section 438.210(d)(1)(2)

FINDING:
The MHP did not provide evidence that it makes an authorization decision and provides notice as expeditiously as the beneficiary's health condition requires and within fourteen (14) calendar days following receipt of the request for service with a possible extension of up to fourteen (14) additional days. Specifically, the DHCS team reviewed 25 standard requests for payment authorization decisions. Two (2) of the 25 standard authorization decisions were not authorized within 14 calendar days. The MHP was found in partial compliance (92%) with this regulatory requirement.

PLAN OF CORRECTION:
The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it makes authorization decisions and provides notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days.

Section B, "Authorization," Questions 6c:

6. Regarding Notices of Action (NOAs):

6c. NOA-C: Is the MHP providing a written NOA-C to the beneficiary when the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination?

CFR, title 42, section 438.10 (c), 438.400(b) and 438.404(c)(2)
CCR, title 9, chapter 11, sections 1830.205(a),(b)(1),(2),(3), 1850.210 (a)-(j)and 1850.212
DMH Letter No. 05-03
MHP Contract, Exhibit A, Attachment I

FINDING:

The MHP did not furnish evidence that Notices of Action (NOA) were provided to beneficiaries in accordance with title 9 regulations. Specifically, DHCS reviewed seventy-five (75) NOA-C's; 25 of the NOA-Cs in this sample were not mailed to the beneficiaries within three (3) working days of taking action. The MHP is in partial compliance (67%) with regulatory requirements for protocol question 6c.

PLAN OF CORRECTION:

The MHP will submit a POC indicating how it will address the OOC finding for this requirement. The MHP must provide evidence to DHCS with evidence of correction for the POC to ensure the MHP, in accordance with title 9 regulations, provides a written NOA-C to the beneficiaries when the MHP denies payment authorization of a service that has already been delivered to the beneficiaries as a result of retrospective payment determination.

Section C, "Beneficiary Protection," Question 4a, 4b, 4c:

4. Does the MHP provide written acknowledgement:

4a. Of each grievance to the beneficiary in writing?

4b. Of each appeal to the beneficiary in writing?

4c. Of each expedited appeal to the beneficiary in writing?

CFR, title 42, section 438.406(a)(2)
CCR, title 9, chapter 11, section 1850.205(d)(4)

FINDING:

The MHP did not provide evidence that the MHP provided written acknowledgement to beneficiaries of each grievance, appeal or expedited appeal in compliance with title 9 regulations. The DHCS review team reviewed five (5) grievances. Four (4) of the five (5) reviewed grievances were in compliance as the MHP presented evidence showing written acknowledgement of each grievance was provided to the beneficiaries in writing. There was one (1) grievance that was not in compliance because the MHP placed a form letter into beneficiary's file instead of appropriately sending written acknowledgement to the beneficiary. The MHP was in partial compliance (80%) with regulatory requirements for protocol question 4a.

PLAN OF CORRECTION:
The MHP will submit a POC indicating how it will address the OOC finding for this requirement. The MHP must provide evidence to DHCS with evidence of correction for the POC to ensure the MHP is providing beneficiaries with written acknowledgement of each grievance, appeal and expedited appeal.

Section C, "Beneficiary Protection," Question 5a:

5. Is the MHP notifying beneficiaries, or their representatives:

5a. Of the grievance disposition and is this being documented?

CFR, title 42, section 438.408 (d
CCR, title 9, chapter 11, sections 1850.206(b)(c), 1850.207 (c)(h) and 1850.208 (d) (e)
DMH Letter No. 05-03

FINDING:
The MHP did not provide evidence that it is notifying beneficiaries, or their representatives, of the grievance disposition and that this is being documented in accordance with title 9 regulations. The DHCS review team reviewed five (5) grievances. Four (4) of the five (5) reviewed grievances were in compliance as the MHP presented evidence showing the MHP is notifying beneficiaries or their representatives of the grievance disposition. There was one (1) grievance that was not in compliance because the MHP did not properly notify the beneficiary of the grievance disposition. The MHP was in partial compliance (80%) with regulatory requirements for protocol question 5a.

PLAN OF CORRECTION:
The MHP will submit a POC indicating how it will address the OOC finding for this requirement. The MHP must provide evidence to DHCS with evidence of correction for the POC to ensure the MHP is notifying beneficiaries or their representatives of the grievance disposition and this is being documented.

Section G, "Provider Relations," Question 2:

2. Does the MHP have an ongoing monitoring system in place that ensures contracted organizational providers are certified and recertified as per title 9 regulations?

CCR, title 9, chapter 11, section 1810.435 (d)(e)
MHP Contract, Exhibit A, Attachment I

FINDING:
The MHP did not provide evidence that it has an ongoing monitoring system in place that ensures contracted organizational providers are certified and recertified in compliance with title 9 regulations. Specifically, the MHP had a policy which met the requirements of this question; however, in practice, at the time of the triennial review, the MHP had twenty-seven (27) providers that were overdue for re-certifications. The MHP was found in partial compliance (55%) with regulatory requirements for protocol question 2.

PLAN OF CORRECTION:
The MHP will submit a POC indicating how it will address the OOC finding for this requirement. The MHP must provide evidence to DHCS with evidence of correction for the

POC to ensure that the MHP has an ongoing monitoring system in place that ensures contracted organizational providers are certified and recertified per title 9 regulations.

CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES
FISCAL YEAR 2014-2015
FRESNO COUNTY REVIEW
MAY 4 – 7, 2015
FINAL REPORT

Section K, "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, for adherence to the terms of the contract between the Fresno 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 **395** claims submitted for the months of April, May, and June of 2014.

Section K, "Chart Review – Non-Hospital Services," Questions 1a-1c:

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 DSM diagnosis contained in the CCR, title 9, section 1830.205(b)(1)(A-R).**
   - **1b. The beneficiary, as a result of a mental disorder 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 that SMHS can correct or ameliorate.**
   - **1c. Must meet each of the intervention criteria listed below:**
     1) **The focus of the proposed intervention 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 that SMHS can correct or ameliorate per No. 1b. (4).**
     2) **The expectation is that the proposed intervention 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.**

- *CCR, title 9, chapter 11, section 1830.205 (b)(c)*
- *CCR, title 9, chapter 11, section1830.210*
- *CCR, title 9, chapter 11, section 1810.345(a)*
- *CCR, title 9, chapter 11, section 1840.112(b)(1) and (4)*
- *CCR, title 9, chapter 11, section 1840.314(d)*
- *CCR, title 22, chapter 3, section 51303(a)*

FINDING:

1c-1. Reason for Recoupment #3 - One or more claims associated with the following Line #s did not meet the medical necessity criteria since the focus of the interventions documented on the progress notes did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A): Line #2 and Line #15.

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance indicated above.

PLAN OF CORRECTION:

1c-1. The MHP shall submit a Plan of Correction (POC) that indicates how the MHP will ensure that interventions 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).

***

FINDING:

1c-2. Reason for Recoupment #4 - One or more claims associated with the following Line #s 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, chapter 11, section 1830.205(b)(3)(B)(1-4): Line #11 and Line #17.

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance indicated above.

PLAN OF CORRECTION:

1c-2. 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).

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Section K, "Chart Review – Non-Hospital Services," Questions 2a-2f:

2. Regarding the Assessment, are the following conditions met:

2a. Has the Assessment been completed in accordance with regulatory and contractual requirements

2b. Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness and frequency?

2c. Does the Assessment 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 situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
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 psychological 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 shall 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 Use.** Past and 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 past or current trauma;
9) **A mental status examination;**
10) **A complete five-axis 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,
11) **Additional clarifying formulation information,** as needed.

2d. Did the provider obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication?

2e. Did the documentation include, but not limited to:

1) **The reasons for taking such medications;**
2) **Reasonable alternatives treatments available, if any;**
3) **The type, range of frequency and amount, methods (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and;**
4) **That the consent, once given, may be withdrawn at any time by the beneficiary.**

2f. Is the documentation legible?

- *CCR, title 9, chapter 11, section 1810.204*
- *CCR, title 9, chapter 11, section 1840.112(b)(1)*
- *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*

FINDING:

2a. Initial and Updated assessments were not completed in accordance with regulatory and contractual requirements:

1) Initial and Updated assessments were not always completed within the timeliness and frequency requirements specified in the MHP's written documentation standards.
2) Assessments did not include all of the required elements specified in the MHP Contract with the Department.

PLAN OF CORRECTION:

2a. The MHP shall submit a POC that:

1) Indicates 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.
2) Indicates how the MHP will ensure that assessments include the required elements and are completed in accordance with regulatory and contractual requirements.

***

FINDING:

2b. Assessments were not completed in accordance with the MHP's written documentation standards for timeliness and frequency:

- Line #5: There was no initial assessment found in the medical record. During the review, MHP staff was given the opportunity to locate the missing assessment but could not locate the document in the medical record.
- Line #1, Line #6, Line #11 and Line #20: The initial assessment was completed late. In addition, for Line #19, the second provider completed an assessment that was late.
- Line #2, Line #7, Line #12, and Line #13: The updated assessment was completed late.

PLAN OF CORRECTION:

2b. The MHP shall submit a POC that indicates how the MHP will ensure that assessments are completed in accordance with the MHP's written documentation standards for timeliness and frequency.

***

FINDING:

2c. One or more of the assessments reviewed did not include all of the required elements as specified in the MHP Contract with the Department.

The following required elements were missing:

1) Medical History: Line #19 (2nd provider's assessment)
2) Substance Exposure/Substance Use: Line #1 and Line #19.
3) Client Strengths: Line #1, Line #4, Line #7, Line #10, Line #13, Line #18 and Line #19.
4) Risks: Line #1, Line #2, Line #6 and Line #7.

PLAN OF CORRECTION:

2c. 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.

***

FINDING:

2d. The provider did not obtain and retain a written medication consent signed by the beneficiary agreeing to the administration of 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:

- Line #1, Line #5 and Line #16: 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.*
- Line #12 and Line #18: Although there was a written medication consent form in the medical record, there was no medication consent for all of the medications prescribed. *During the review, MHP staff was given the opportunity to locate the medication consents in question but was unable to locate them in the medical record.*

PLAN OF CORRECTION:

2d. The MHP shall submit a POC that indicates how the MHP will ensure that:

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 timeliness and frequency standards specified in the MHP's written documentation standards.

***

FINDING:

2e. Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department:

- For Line #2, Line #3, Line #4, Line #6, Line #7, Line #8, Line #9, Line #11, Line #12, Line #13, Line #14, Line #15, Line #18 and Line #20, one or more of the following required elements were not documented on the medication consent forms found in the beneficiary's medical record:

  Reason for taking each medication; reasonable alternative treatment available, if any; range of frequency and amount, method of administration (oral or injection); duration of taking each medication; additional side effects which may occur when taking the medication beyond three (3) months.

PLAN OF CORRECTION

2e. The MHP shall submit a POC that indicates how the MHP will ensure that every medication consent includes documentation of all of the required elements specified in the MHP Contract with the Department.

***

Section K, "Chart Review – Non-Hospital Services," Questions 3a-3i:

3a. Has the client plan been completed in accordance with regulatory and contractual requirements?
3b. Has the client plan been updated at least annually, or when there are significant changes in the beneficiary's condition?
3c. Does the client plan contain the following 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 intervention/modality including a detailed description of the intervention to be provided,
3) The proposed frequency and duration of intervention(s),
4) Interventions that focus and address the identified functional impairments as a result of the mental disorder,
5) Interventions that are consistent with client plan goal(s)/treatment objective(s),
6) Be consistent with the qualifying diagnoses.
3d. Is the client plan signed (or electronic equivalent) by, at least, one (1) of the following (1, 2, or 3):
1)A person providing the services,
2)A person representing a team or program providing the service(s),
3)A person representing the MHP providing services.
By one of the following as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not of the approved categories, one (1) of the following must sign:
1) A Physician
2) A Licensed/Waivered Psychologist
3) A Licensed/Registered/Waivered Social Worker
4) A Licensed/Registered/Waivered Marriage and Family Therapist
5) Licensed/Registered/Waivered Professional Clinical Counselor (pending Centers for Medicare and Medicaid Services (CMS) approval)
6) A Registered Nurse including but not limited to nurse practitioners and clinical nurse specialists.
3e. Is there documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced by, but not limited to:
1) Reference to the beneficiary's participation in and agreement in the body of the client plan or
2) The beneficiary's signature on the client plan; or
The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:
1) The beneficiary is expected to be in a long-term treatment, as determined by the MHP, and,
2) The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS.
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 shall include a written explanation of the refusal or unavailability.
3f. Does the MHP have a written definition of what constitutes a long term care beneficiary?
3g. Is there documentation that the contractor offered a copy of the client plan to the beneficiary?
3h. Is the documentation legible?

- *CCR, title 9, chapter 11, section 1810.205.2*
- *CCR, title 9, chapter 11, section 1810.264*
- *CCR, title 9, chapter 11, section 1840.314*
- *CCR, title 9, chapter 11, section 1810.440(c)*
- *CCR, title 9, chapter 11, section 1840.112(b)(5)*
- *DMH Letter 02-01, Enclosure A*
- *W&IC, section 5751.2*

FINDING:

3a. The client plan was not completed in accordance with regulatory and contractual requirements.

1) The MHP was not always following contractual requirements and/or its own written documentation standards for timeliness and frequency, goal and intervention requirements on its client plans.

PLAN OF CORRECTION:

3a. The MHP shall submit a POC that indicates how the MHP will ensure that client plans:

1) Are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.
2) Contain goals/objectives and proposed interventions in accordance with regulatory and contractual requirements.
3) Are updated at least annually or when there are significant changes in the beneficiary's condition in accordance with regulatory and contractual requirements.

***

FINDING:

3a. Reason for Recoupment #5 – The initial client plan was not completed within the time period specified in the MHP's documentation standards, with no evidence supporting the need for more time:

- Line #19: The initial client plan was not completed within the time period specified in the MHP's documentation standards, and therefore, there was no client plan in effect during part of the audit review period. *The MHP should review all services and claims during which there was no initial client plan in effect and disallow those claims as required.*
- Line #5: There was no initial client plan in the medical record within the time period specified in the MHP's written documentation standards. However, this occurred prior to the audit review period. *The MHP should review all the services and claims during which there was no initial client plan in effect and disallow those claims as required.*

PLAN OF CORRECTION:

3a. The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that initial client plans are completed in accordance with the MHP's written documentation standards.
2) Ensure that the interventions/modalities on the client plans are clear, specific, detailed and address the beneficiary's identified functional impairments as a result of the mental disorder.
3) Ensure that services are not claimed:
   a) When an initial client plan has not been completed.
   b) When not indicated on the initial client plan.
4) Provide evidence that those services claimed outside of the audit review period for which there were no client plans in effect are disallowed.

***

FINDING:

3a, 3b. Reason for Recoupment #6 – The client plan was not updated at least annually, as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards:

- Line #10: There was no updated client plan in the medical record. During the review, MHP staff was given the opportunity to locate the document in question but could not find written evidence of it in the medical record. *The MHP should review all services and the claims during which there was no client plan in effect and disallow those claims as required.*
- Line #1: There was no updated client plan for one or more type of service being claimed. During the review, MHP staff was given the opportunity to locate the services in question on a client plan but could not find written evidence of it. *The MHP should review all services and claims during which there was no client plan for the services in question and disallow those claims as required.*
- Line #15: 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. *The MHP should review all services and claims during which there was no client plan in effect and disallow those claims as required.*
- Line #1 and Line #16: There was a lapse between the prior and current client plans. However, this occurred outside of the audit review period. *The MHP should review all services and claims outside of the audit review period during which there was no client plan in effect and disallow those claims as required.*

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance indicated above.

PLAN OF CORRECTION:

3a, 3b. 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 MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.
2) Ensure that all types of interventions/service modalities provided and claimed are recorded as proposed interventions on a current client plan.
3) Ensure that all interventions/modalities recorded on client plans are clear, specific, detailed and address the beneficiary's identified functional impairments as a result of the mental disorder.
4) Ensure that non-emergency services are not claimed when:
    a) A client plan has not been completed.
    b) The service provided is not included on the current client plan.
5) Provide evidence that all services claimed outside of the audit review period for which no client plan was in effect are disallowed.

***

FINDING:

3a, 3b. The client plan was not updated when there was a significant change in the beneficiary's condition, as required in the MHP Contract with the Department:

- Line #5: The effective dates of the current client plan were 4/28/2014 to 4/27/2015. The medical record indicates that the beneficiary was seen in Crisis Intervention on multiple occasions during the effective dates of the current plan. However, there was no documentation that the client plan was reviewed and updated in response to these emergency services.
- Line #6: The effective dates of the current client plan were 10/29/2013 to 10/28/2014. The medical record indicates that the beneficiary received both Crisis Intervention and Crisis Stabilization services during the effective dates of the current plan. However, there was no documentation that the client plan was reviewed and updated in response to these emergency services.

PLAN OF CORRECTION:

3a, 3b. The MHP shall submit a POC that indicates how the MHP will ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

***

FINDING:

3c-1-3. The following Line #s had client plans that did not include all of the items specified in the MHP Contract with the Department:

1) **3c-1.** Line #1, Line #2, Line #14, Line #18 and Line #19: 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.
2) **3c-2.** Line #1, Line #2, Line #7, Line #12, Line #13, Line #14, Line #15, Line #17, Line #18 and Line #19: 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.).
3) **3c-3.** Line #1, Line #4, Line #17 and Line #20: One or more of the proposed interventions did not indicate an expected frequency.

PLAN OF CORRECTION:

3c-1-3 The MHP shall submit a POC that indicates 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.

***

FINDING:

3g. There was inadequate documentation that the beneficiary or legal guardian was offered a copy of the client plan for the following Line #s: Line #1, Line #4 and Line #14.

PLAN OF CORRECTION:

3g. 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 and whether or not he/she received a copy of the client plan.

***

Section K, "Chart Review – Non-Hospital Services," Questions 4a-4d:

4. Do the progress notes describe how services provided reduced impairment,
   - 4a. restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan?
   - 4b. 1) Timely documentation of relevant aspects of client care, including documentation of medical necessity;
     2) Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
     3) Interventions applied, beneficiary's response to the interventions and the location of the interventions;
     4) The date the services were provided;
     5) 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, licensure or job title; and the relevant identification number, if applicable.
     9) The date the service was documented in the medical record by the person providing the service.
   - 4c. Timeliness/frequency as follows:
     1) Every service contact 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.
   - 4d. Is the documentation legible?

- *CCR, title 9, chapter 11, section 1810.254*
- *CCR, title 9, chapter 11, section 1810.440(c)*
- *CCR, title 9, chapter 11, section 1840.314*
- *CCR, title 9, chapter 11, sections 1840.316 - 1840.322*
- *CCR, title 9, chapter 11, section 1840.112(b)(3)(6)*
- *CCR, title 22, chapter 3, section 51458.1*
- *CCR, title 22, chapter 3, section 51470*

NOTE:

4a-d: Multiple progress notes used for the purpose of claiming Federal Financial Participation (FFP) Specialty Mental Health Services (SMHS) were disallowed.

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance listed below.

***

FINDING:

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

1) One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements.
2) The MHP was not following its own written documentation standards for timeliness of staff signatures on progress notes.

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 requirements.
2) Provide evidence that the MHP has written documentation standards for progress notes, including required elements, timeliness and frequency as required in the MHP Contract with the Department.
3) Describe how the MHP will ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

***

FINDING:
4a, 4b. Reason for Recoupment #9:

- **4a, 4b.** Line #1: There was no progress note in the medical record for the service claimed.

  During the review, the MHP staff was given the opportunity to locate the documents in question but could not find written evidence of them in the medical record.

- **4b.** Line #5, Line #7 and Line #17: The type of SMHS documented on the progress note was not the same type of SMHS claimed.

During the review, MHP staff was given the opportunity to locate any missing document for any disallowance indicated above but could not find written evidence of the document in the medical record.

PLAN OF CORRECTION:
4a, 4b. 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.
   e) Claimed to provider who actually provided the services.
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.

***

FINDING:

4b-1, 4b-8. Progress notes did not document the following:

1) **4b-1.** Line #1, Line #2, Line #7, Line #13, Line #14, Line #15, Line #17, Line #18, Line #19 and Line #20: 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).
2) **4b-8.** Line #18: The provider's professional degree, licensure or job title.

PLAN OF *CORRECTION*:

4b-1, 4b-8. The MHP shall submit a POC that indicates 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 the MHP's written documentation standards.
2) The provider's professional degree, licensure or job title.

***

FINDING:

4b-3, 4b-7. Reason for Recoupment #14 - The claim for a group activity was not properly apportioned to the beneficiary participating in the group:

- Line #7 and Line #12: There was an inaccurate calculation of time apportioned for the claim based on the information recorded on the progress note (i.e., based on direct service time, travel and documentation times and the identification of each group facilitator involved in the session).
- Line #7: Progress notes did not document the contribution, involvement or participation of each group facilitator as it relates to the identified functional impairment and mental health needs of the beneficiary.

PLAN OF CORRECTION:

4b-3, 4b-7. The MHP shall submit a POC that indicates how the MHP will ensure that:

1) The number of clients in the group, number of staff, units of time, type of service and dates of service (DOS) documented on the group progress notes are accurate and consistent with the documentation in the medical record and that services are not claimed when billing criteria are not met.
2) If group sessions involve more than a single facilitator, progress notes clearly identify each group facilitator and document the contribution, involvement or participation of each as it relates to the identified functional impairment and mental health needs of the beneficiary.
3) There is medical necessity for the use of multiple staff facilitators in the group setting.

***

FINDING:
Progress notes for the following Line #s indicate that the service provided was solely for:

1) **Reason for Recoupment #16** - Transportation: Line #17.
2) **Reason for Recoupment #17** - Clerical: Line #7.

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 outlined in the client plan.
2) Services provided and claimed are not solely transportation, clerical or payee related activities.
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).

***

Section K, "Chart Review – Non-Hospital Services," Questions 5a-f:

5. Have *Day Treatment Intensive* and *Day Rehabilitation* services been provided in accordance with regulatory and contractual requirements?

5a. Service Components:
1) Do *Day Treatment Intensive* and *Day Rehabilitation* programs include all the following required service components:
   A. Daily Community Meetings;
   B. Therapeutic Milieu;
   C. Process Groups;
   D. Skill-building Groups; and
   E. Adjunctive Therapies?
2) In addition:
   A. Does *Day Treatment Intensive* include Psychotherapy?
   B. Community meetings must occur at least once a day and have the following staffing:
   C. For *Day Treatment Intensive*: Staff whose scope of practice includes psychotherapy
   D. For *Day Rehabilitation*: Staff who is a physician, a licensed/waivered/ registered psychologist, clinical social worker, or marriage and family therapist, a registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist.

5b. 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?

5c. Continuous Hours of Operation:
Did the provider apply the following when claiming for the continuous hours of operation of *Day Treatment Intensive* and *Day Rehabilitation* services?
A. For Half Day: The beneficiary received face-to-face services a minimum of three (3) hours each day the program was open.
B. For Full-Day: The beneficiary received face-to-face services in a program with services available more than four (4) hours per day.

5d. Staffing Requirements:
1) Do *Day Treatment Intensive* and *Day Rehabilitation* meet the following staffing requirements:
   A. For *Day Treatment Intensive*: Psychotherapy is provided by licensed, registered, or waivered staff practicing within their scope of practice.
   B. For all scheduled hours of operation: There is at least one staff person present and available to the group in the therapeutic milieu.

5e. Documentation Standards:
1) Is the required documentation timeliness/frequency for *Day Treatment Intensive* or *Day Rehabilitation* being met?
   A. For *Day Treatment Intensive* services:
      - Daily progress notes on activities; and
      - A weekly clinical summary.
   B. For *Day Rehabilitation* services:
      - Weekly progress note.
2) Do all entries in the beneficiary's medical record include:
   A. The date(s) of service;
   B. The signature of the person providing the service (or electronic equivalent);
   C. The person's type of professional degree, licensure or job title;
   D. The date of signature;
   E. The date the documentation was entered in the beneficiary record; and
   F. The total number of minutes/hours the beneficiary actually attended the program?

5f. Written Program Description:
1) Is there a Written Program Description for *Day Treatment Intensive* and *Day Rehabilitation*?
   A. Does the Written Program Description describe the specific activities of each service and reflect each of the required components of the services as described in the MHP Contract.
2) Is there a Mental Health Crisis Protocol?
3) Is there a Written Weekly Schedule?
   A. Does the Written Weekly Schedule:
      a) Identify when and where the service components will be provided and by whom; and
      b) Specify the program staff, their qualifications, and the scope of their services?

FINDING:

5a. Reason for Recoupment #19a – Documentation for the following Line # indicated that essential requirements for a Day Treatment Intensive (DTI) program were not met, as specified by the MHP Contract with the Department:

1) Line #1: Community meetings were not documented to have been provided and attended by the beneficiary at least once a day.
2) Line #1: Process groups were not documented to have been provided and attended by the beneficiary as part of the program milieu.

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance indicated above.

PLAN OF CORRECTION:

5a. The MHP shall submit a POC that indicates how the MHP will ensure that all program requirements for *Day Rehabilitation (DR)* and *DTI* are provided in accordance with regulatory and contractual requirements. For example:

1) Ensure that all the required service components, including daily community meetings and process groups, are met and documented.
2) Ensure that the community meetings occur at least once a day
3) Ensure that staffing for *DTI* community meetings include staff whose scope of practice included psychotherapy.
4) Ensure that staffing for *DR* community meetings include a physician, a licensed/waivered/ registered psychologist, clinical social worker, or marriage and family therapist; registered nurse, psychiatric technician, licensed vocational nurse, or a mental health rehabilitation specialist.
5) Provide evidence that all *DTI* claims outside the audit review period are recouped when the required service components are not met and when required frequency and staffing requirements for community meetings and all other required service components are not met.

***

FINDING:

5f-1. The Written Program Description for *DTI* did not clearly reflect all of the required service components - as described in the MHP Contract - for the following Line #: Line #1.

PLAN OF CORRECTION:

5f-1. The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that the Written Program Description for any MHP-contracted *DTI* and *DR* program describes the specific activities of each service component required in the MHP Contract.
2) Provide evidence that there is a full and complete Written Program Description for any *DTI and DR* program under contract with, or provided by, the MHP.

***

FINDING:

5f-3. The Written Weekly Schedule for *DTI* did not clearly identify:

1) **5f-3A-a.** Line #1: The provision of Process Groups and daily Community Meetings.
2) **5f-3A-b.** Line #1: All program staff and their qualifications for each service activity required by the MHP Contract with the Department.

PLAN OF CORRECTION:

5f-3. The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that there is a Written Weekly Schedule for *DTI* programs with all required components.
2) Ensure that the Written Weekly Schedules for *DTI* programs identify when and where the service components will be provided and by whom;
3) Ensure that the Written Weekly Schedules for *DTI* programs identify all program staff and specifies their qualifications and scope of their services
4) Provide evidence that there are current Written Weekly Schedules for *DTI* programs that are updated whenever there is any change in program staff and/or schedule.

***

Section K, "Chart Review – Non-Hospital Services," Question 6i-iii:

6. Do all entries in the beneficiary's medical record include:
- **i. Date of service?**
- **ii. The signature of the person providing the service or (electronic equivalent) with the person's professional degree, licensure or job title AND**
- **iii. The date the documentation was entered in the medical record?**

FINDING:

6-i. The entries in the beneficiary's medical record did not include the following:

1) **6-iii.** Date the documentation was entered into the medical record:
   - Medication consent signature date: Line #5.

PLAN OF CORRECTION:

6-i. The MHP shall submit a POC that indicates how the MHP will ensure that all documentation includes the date the date of signature to identify when the document was completed and entered into the medical record.

***

State of California
Department of Health Care Services

Recoupment Summary
Confidential Patient Information
See California Welfare and Institutions Code Section 5328 and HIPAA Privacy and Security Rules
April 2014 - June 2014
FRESNO COUNTY

Total Claims: 395
Total Out of Compliance: 89 **Percent Out of Compliance:** 23%

LINE #	PROV #	DATE OF SERVICE	MODE	SF	UNITS OF TIME	AMOUNT APPROVED	FFP	RR#	REASON(S) FOR RECOUPMENT	FMAP	APPROVED AIDCODE
1	10DP	20140523	18	60	105	$506.10	$253.05	6, 7	Intervention claimed not on updated Client Plan; No documentation of beneficiary participation/agreement with the missing intervention.	50.00	42
1	10DP	20140602	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140603	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140604	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140606	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140609	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140610	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140611	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140612	18	85	1	$202.43	$101.21	9	Missing note: no matching progress note and MHP staff unable to locate it in the medical record.	50.00	42
1	10DP	20140613	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140614	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140616	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140617	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140618	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140619	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140620	18	60	30	$144.60	$72.30	6, 7	Intervention claimed not on updated Client Plan; No documentation of beneficiary participation/agreement with the missing intervention.	50.00	42
1	10DP	20140620	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42

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1	10DP	20140623	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140624	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140625	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140626	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
1	10DP	20140627	18	85	1	$202.43	$101.21	19a	Required service component (community meeting) not documented as scheduled and provided.	50.00	42
2	10C9	20140423	18	01	25	$45.00	$45.00	3, 4	Does not meet medical necessity: Submitted QI report re. incarceration.	100.00	M1
4	10DS	20140620	18	60	30	$112.50	$56.25	9	Missing note: no matching progress note and MHP staff unable to locate it in the medical record.	50.00	60
5	10AP	20140502	18	70	20	$85.00	$42.50	9	Service claimed does not match service on progress note: Content of note documents a phone call that is not Crisis Intervention.	50.00	K1
5	10AP	20140527	18	01	30	$66.30	$33.15	9	Service claimed does not match service on progress note: Content of note is not a Case Mgt. intervention.	50.00	K1
6	1044	20140529	18	60	25	$131.75	$65.87	9	Missing note: no matching progress note and MHP staff unable to locate it in the medical record.	50.00	60
7	10C4	20140407	18	30	57	$163.02	$163.02	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	100.00	M1
7	10C4	20140414	18	30	57	$163.02	$163.02	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	100.00	M1
7	1090	20140521	18	1	50	$110.50	$110.50	9	No matching Progress Note: Service claimed does not match service on progress note: Content of note is MH Rehab., not Case Mgt.	100.00	M1
7	1090	20140527	18	1	50	$110.50	$110.50	17, 3, 4	Filled out paperwork for SSI; Does not meet medical necessity.	100.00	M1
7	1090	20140624	18	1	40	$88.40	$88.40	9	No matching Progress Note: Service claimed does not match service on progress note: Content of note is MH Rehab., not Case Mgt.	100.00	M1
8	1045	20140429	18	60	160	$843.20	$421.60	6	Client Plan not completed at least on an annual basis: Lapse of coverage between Client Plans.	50.00	42
8	1045	20140429	18	60	25	$131.75	$65.87	6	Client Plan not completed at least on an annual basis: Lapse of coverage between Client Plans.	50.00	42

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10	10CY	20140402	18	30	22	$57.42	$28.71	6, 9	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record; No matching Progress Note - service time/duration missing on note with same date as claim.	50.00	60
10	10CY	20140402	18	30	60	$156.60	$78.30	6	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record.	50.00	60
10	10CY	20140416	18	30	63	$164.43	$82.21	6	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record.	50.00	60
10	10CY	20140424	18	30	22	$57.42	$28.71	6	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record.	50.00	60
10	10CY	20140430	18	30	63	$164.43	$82.21	6	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record.	50.00	60
10	10CY	20140514	18	30	25	$65.25	$32.62	6, 9	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record; No matching Progress Note - service time/duration missing on note with same date as claim.	49.99	60
10	10CY	20140521	18	30	19	$48.47	$24.23	6, 9	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record; No matching Progress Note - service time/duration missing on note with same date as claim.	49.99	60
10	10CY	20140528	18	30	22	$57.42	$28.71	6, 9	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record; No matching Progress Note - service time/duration missing on note with same date as claim.	50.00	60
10	10CY	20140604	18	30	18	$45.68	$22.84	6, 9	No updated Client Plan covering review period and MHP staff unable to locate it in the medical record; No matching Progress Note - service time/duration missing on note with same date as claim.	50.00	60
11	10CY	20140519	18	30	57	$148.77	$74.38	4, 3	Does not meet medical necessity: Progress Note did not describe clearly how (gardening) would reduce impairment or prevent deterioration no intervention by group facilitator was documented.	50.00	60
12	1040	20140610	18	30	40	$114.40	$57.20	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140611	18	30	36	$102.96	$51.48	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60

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12	1040	20140611	18	30	20	$57.20	$28.60	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140612	18	30	36	$102.96	$51.48	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140613	18	30	25	$71.50	$35.75	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140616	18	30	36	$102.96	$51.48	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140616	18	30	2	$5.72	$2.86	17, 19, 4	Solely clerical activity documented on note; No service provided - missed/canceled appointment.	50.00	60
12	1040	20140617	18	30	33	$94.38	$47.19	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140618	18	30	36	$102.96	$51.48	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140619	18	30	40	$114.40	$57.20	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140624	18	30	40	$114.40	$57.20	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140625	18	30	40	$114.40	$57.20	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140626	18	30	33	$94.38	$47.19	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140626	18	30	21	$60.06	$30.03	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
12	1040	20140627	18	30	30	$85.80	$42.90	14	Group activity not properly apportioned: Inaccurate calculation of billed time.	50.00	60
15	10C4	20140418	18	30	33	$94.38	$94.38	3, 4	Intervention does not address mental health condition and does not meet medical necessity.	100.00	M1
15	10C4	20140425	18	30	40	$114.40	$114.40	3, 4	Intervention does not address mental health condition and does not meet medical necessity.	100.00	M1
15	10C4	20140502	18	30	40	$114.40	$114.40	6	Lapse of coverage between Client Plans - prior Plan expired 4/29/2014 & new Plan completed-signed 5/29/2014	100.00	M1
15	1044	20140506	18	60	31	$163.37	$163.37	6	Lapse of coverage between Client Plans - prior Plan expired 4/29/2014 & new Plan completed-signed 5/29/2014	100.00	M1

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15	10C4	20140523	18	30	70	$200.20	$200.20	6, 3	Lapse of coverage between Client Plans - prior Plan expired 4/29/2014 & new Plan completed-signed 5/29/2014	100.00	M1
17	10DB	20140502	18	1	28	$61.88	$30.94	9	No matching progress note: Service claimed does not match service documented on progress note - MH Rehab. provided with no Case Mgt. interventions.	50.00	5F
17	10DB	20140514	18	1	126	$278.46	$139.23	9	No matching progress note: Service claimed does not match service documented on progress note - MH Rehab. provided with no Case Mgt. interventions.	50.00	5F
17	10DB	20140521	18	30	13	$37.18	$18.59	4, 9, 3	Claimed as Individual Therapy but service was a phone call regarding family issues; Service claimed does not match service documented on progress note.	50.00	5F
17	10DB	20140604	18	1	20	$44.20	$22.10	16, 3	Solely transportation documented and does not meet medical necessity.	50.00	M4
19	10CI	20140509	18	30	135	$352.35	$176.17	5, 7	Beneficiary signature required but not signed as of service date with no explanation; Client Plan not completed (signed) within the MHP's written timeliness standard.	50.00	32
19	10CI	20140514	18	30	60	$156.60	$78.30	5, 7	Beneficiary signature required but not signed as of service date with no explanation; Client Plan not completed (signed) within the MHP's written timeliness standard.	50.00	32
19	10CI	20140515	18	30	49	$127.89	$63.94	5, 7	Beneficiary signature required but not signed as of service date with no explanation; Client Plan not completed (signed) within the MHP's written timeliness standard.	50.00	32
20	10DF	20140620	18	60	2	$9.64	$4.82	17, 3	Solely clerical activity documented on note; Does not meet medical necessity.	50.00	30
						$10,118.88	**$5,742.90**				