SECTION 10: SITE CERTIFICATION/MEDICAL RECORD REVIEW

10.0 Site Certification/Recertification

In order for a provider to receive Medi-Cal beneficiary referrals and begin billing for services, the provider must first be Medi-Cal certified by the Department of Health Care Services through its local Mental Health Plan (MHP). The Fresno County Mental Health Plan (FCMHP) is required to conduct a Medi-Cal site certification during the credentialing process to ensure compliance with all federal and state guidelines; however, the exact timing will be up to the discretion of the FCMHP. Compliance with site certification standards is monitored by FCMHP staff. (Refer to Certification Survey Checklist, the Individual and Group Provider Site Certification form, and the Organizational Provider Facility Site form, at the end of this section).

For **Individual and Group providers**, site recertification will also be conducted whenever a provider changes an office or treatment site during the contract period. The FCMHP may revisit the site, as necessary, to follow-up on any areas requiring compliance correction. The provider is required to correct any deficiency(ies) and demonstrate compliance of site certification requirements to the FCMHP within 30 days of notification.

For **Organizational providers**, an additional certification review may be conducted when:

- The provider makes major staffing changes.
- The provider makes organizational and/or corporate structure changes (e.g., conversion from non-profit status).
- The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.
- There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).
- There is change of ownership or location.
- There are complaints against the provider.

- There are unusual events, accidents or injuries requiring medical treatment for clients, staff or members of the community.

Failure to provide evidence of correction of or compliance with the deficiencies within the 30 days will result in withholding of payments for current and future claims and/or contract termination.

10.1 Medical Record Review

The FCMHP staff may perform an onsite medical records review annually or when circumstances indicate oversight is needed. If medical record keeping does not meet standards, the FCMHP may potentially withhold payment as stated in the contractual agreement until a satisfactory Plan of Correction is submitted. Subsequent visits will be made as necessary to follow-up on any areas requiring correction. The provider is required to correct any deficiencies and to demonstrate correction of these deficiencies to the FCMHP staff. (Please refer to FCMHP Chart Review Summary Checklist and How to Fill-out the Plan of Correction Form at the end of this section.)

10.2 Reasons for Recoupment or Disallowance during a Medical Record Review

- Documentation in the chart does not establish that the client has an included ICD-10 diagnosis per California Code of Regulations, (CCR) title 9, chapter 11, section 1830.205(b)(1)(A-R).

- Documentation in the chart does not establish that, as a result of a mental disorder, the client has at least one of the following impairments:

    - A significant impairment in an important area of life functioning

    - A probability of significant deterioration in an important area of life functioning

    - A probability that the child will not progress developmentally as individually appropriate

    - For clients under the age of 21, a defect or mental illness that specialty mental health services can correct or ameliorate

- Documentation in the chart does not establish that the focus of the proposed intervention is to address:
    - A significant impairment in an important area of life functioning; or
    - A probability of significant deterioration in an important area of life functioning; or
    - A probability the child will not progress developmentally as individually appropriate; and
    - For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental health disorder that specialty mental health services can correct or ameliorate.
- Documentation in the chart does not establish the expectation that the proposed intervention will do, at least one of the following:
    - Significantly diminish the impairment
    - Prevent significant deterioration in an important area of life functioning
    - Allow the child to progress developmentally as individually appropriate
- The Plan of Care was not completed prior to provision of all planned specialty mental health services.
- The initial Plan of Care (a.k.a. client plan, treatment plan) was not completed within 60 days of the intake unless there is documentation supporting the need for more time.
- The Plan of Care was not completed, at least, on an annual basis or as specified in the MHP's documentation guidelines.
- No documentation of client or legal guardian participation in and agreement with the plan or written explanation of the client's refusal or unavailability to sign as required.
- No progress note was found for service claimed. Every claim for service must be supported by a progress note or clinical

documentation that must be present in the client record prior to the submission of the claim.

- The time claimed was greater than the time documented. Recoupment of the entire service on that date will be implemented. There will be no partial recoupment.

- The progress note indicates that the service was provided while the client resided in a setting where the client was ineligible for FFP, i.e. IMD, jail, and other similar settings, or in a setting subject to lockouts per Title 9 CCR, Chapter 11.

- The progress note clearly indicates that the service was provided to a client in juvenile hall and when ineligible for Medi-Cal.

- The progress note indicates that the service provided was for academic, educational, vocational service that has work or work training as its actual purpose, recreation, or socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific target behaviors.

- The claim for a group activity was not properly apportioned to all clients present.

- The progress note did not contain the signature of the person providing the service.

- The progress note indicates that the service provided was solely transportation.

- The progress note indicates that the service provided was solely clerical.

- The progress note indicates that the service provided was solely payee related.

- No service was provided, or the progress note indicates activities not consistent with the type of service contact claimed.

- The service was not provided within the scope of practice of the person delivering the service.

- The progress note was not legible.

- Missed appointments (as no services provided) are not reimbursable.

- Personal care services performed for the client are not reimbursable. Examples include grooming, personal hygiene, assisting with medication, child or respite care, housekeeping, and the preparation of meals.

- Travel time between two provider sites (i.e. two billing providers, or the provider's second office) is not reimbursable. Travel time may only be claimed from a provider site to an off-site location (i.e. client's home). Provider sites include satellites and school site operations.

10.3 Site and Medical Record Review Procedure

- The FCMHP staff will contact the provider to arrange a convenient date and time for the review.

- The provider is expected to provide the FCMHP staff with all materials requested for review on the date, at the time agreed upon. Any additional or missing documentation must be provided prior to the reviewers' departure on the date of audit.

- The FCMHP will send the provider an audit summary within 30 calendar days after the review. The provider will be asked to make corrective actions, if necessary, by completing the Statement of Deficiencies and Plan of Correction Form. (Refer to form at the end of this section).

- The FCMHP will ask providers for a Plan of Correction based on the following deficiencies.

    - Notes are illegible.

    - Treatment does not address the primary DSM-V diagnosis, i.e., treatment is not consistent with the presenting mental health symptoms.

    - Interventions are not consistent with the behavioral goals on the Plan of Care (except during crisis visits).

    - Notes are not specific and individualized to the client.

    - Specific strategies or techniques used as interventions are not documented.

    - Notes are not consistent with the type of service being billed.

- Failure to submit the Plan of Correction form within 30 days of receipt of the audit summary will result in withholding of payment for current and future claims and/or contract termination.

- Providers who were asked to make corrective actions will receive a follow-up audit summary stating the FCMHP's response to the proposed corrections.

- Appeals process following a medical records review

  - Immediately following the medical records review, the provider will receive a copy of the *FCMHP Missing Documentation and Potential Disallowance Worksheet* that specifies the disallowed claims and the amounts to be recouped.

  - If the provider wishes to appeal any of the recoupment findings, the provider may do so by submitting an appeal, in writing, within ten (10) working days after the receipt of the *FCMHP Missing Documentation and Potential Disallowance Worksheet*. Please address the appeal to the attention of:

    Clinical Supervisor, Appeals
    Department of Behavioral Health
    Managed Care Division
    P.O. Box 45003
    Fresno, California 93718-9886

  - Please send an electronic version of the appeal to mcare@FresnoCountyCA.gov

  - Any claimed service without supporting documentation noted during the onsite review will be automatically disallowed, unless the provider is able to provide evidence of missing documentation during the day of the review, while the reviewers are on-site. Documentation submitted after the date of the medical records review will not be accepted.

- For Institute(s) of Mental Diseases (IMD) or Out-of-County, non-contracted inpatient psychiatric hospitals that see Fresno County Medi-Cal beneficiaries, the FCMHP may visit the IMD or hospital facility(ies) and perform a medical record review of Fresno County cases, to ensure compliance with FCMHP standards.

Section 10:

Site Certification/Medical Record Review

Forms and Attachments

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FRESNO COUNTY MENTAL HEALTH PLAN
INDIVIDUAL/GROUP PROVIDER SITE CERTIFICATION CHECKLIST

☐ Initial Certification ☐ Fire Clearance Date: Click or tap to enter a date.

Date of Onsight Review: Click or tap to enter a date. Provider Type: Choose an item.

Provider Name: _____ Provider #: _ _____

Address: _____ Phone #: _____

City/State/ZIP: _____ Fax #: _____

Hours of Service: _____ % of Medi-Cal: _____

When you schedule appointments, do you place any restrictions on times when Medi-Cal clients can be seen?
☐ Yes ☐ No

Date provider attended County's Documentation & Billing/Compliance Training: Click or tap to enter a date.

Average No. of Medi-Cal Beneficiaries Served (Monthly): Ages Served:

SITE CERTIFICATION SUMMARY

☐ Certification/Re-certification approved effective Click or tap to enter a date. to Click or tap to enter a date.

☐ Certification/Re-certification approved effective Click or tap to enter a date. to Click or tap to enter a date. with recommendations below:

☐ **Plan of Correction (POC) required** (see "Comments" section of any item checked not in compliance).
POC must be submitted on the provided form within 30 days of the date of this notification.

OTHER FINDINGS:

FOLLOW-UP:

REVIEWERS: _____ Title: _____ Date: Click or tap to enter a date.

_____ Title: _____ Date: Click or tap to enter a date.

Distribution: ☐ Original to Provider ☐ Credentialing File ☐ DBH Contracts Staff Analyst Other

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FRESNO COUNTY MENTAL HEALTH PLAN
SITE CERTIFICATION CHECKLIST
Individual/Group Provider

PROVIDER NAME: _____ **DATE OF REVIEW:** _____

Documents Required (Collected prior to completion of on-site visit):				
	Criteria Met			**Comments/Guidelines for Review**
	Yes	**No**	**N/A**	
Head of Service Licensure/Evidence	☐	☐	☐	
Fire Clearance/Fire Inspection Report with no violations (dated within past 12 months)	☐	☐	☐	
Commercial General Liability Insurance w/limits per Agreement	☐	☐	☐	
Automobile Liability Insurance w/limits per Agreement	☐	☐	☐	NOTE: Only required if the provider will be using their vehicle in the course of the provision of services (i.e., traveling out to the community to provide therapy)
Professional Liability Insurance with limits per Agreement	☐	☐	☐	
Child Abuse/Molestation and Social Services Liability Coverage (may be specific endorsement on General Commercial Liability policy/umbrella or separate policies)	☐	☐	☐	
For providers employing associates: Workers Compensation Insurance	☐	☐	☐	

ON SITE REVIEW **All Providers: Categories 1-3; Providers with Medication Support: Categories 1-4**				
CATEGORY 1: OFFICE/FACILITY	**Criteria Met**			**Comments/Guidelines for Review**
EVALUATION CRITERIA	**Yes**	**No**	**N/A**	
1. The office/facility and its property are clean, sanitary, and in good repair, free from hazards that might pose a danger, with fire exits clear and unobstructed.	☐	☐	☐	
2. Sufficient, confidential space allocated for client and office administrative services.	☐	☐	☐	
3. ADA requirements: Building is maintained in a manner to provide for physical safety of consumers, visitors, personnel and meets ADA accessibility	☐	☐	☐	
a. Office/facility is wheelchair accessible.	☐	☐	☐	
b. Handicapped accessible restroom is available.	☐	☐	☐	
c. Designated handicapped parking is available.	☐	☐	☐	
4. Mental Health Plan Consumer Handbook, grievance forms, appeal/expedited appeals forms, change of	☐	☐	☐	

	provider forms and self-addressed envelopes are available in a prominent area.				
5.	Office has FCMHP postings on display that explain the grievance, appeal, expedited appeal, and fair hearings processes (Spanish, Hmong, and/or other translations as it applies to provider credentialing).	☐	☐	☐	
6.	Written information about obtaining emergency care during non-office hours is posted and available.	☐	☐	☐	
CATEGORY 2: CULTURAL ISSUES		**Criterial Met**			**Comments/Guidelines for Review**
EVALUATION CRITERIA		**Yes**	**No**	**N/A**	
1.	Evidence provider attends an annual training (either County-sponsored or equivalent) on cultural issues of persons served.	☐	☐	☐	
2.	Consumer information and consent forms are available in the consumer's primary language if need be, or an interpreter can be made available.	☐	☐	☐	
CATEGORY 3: MEDICAL RECORDS/CONFIDENTIALITY		**Criteria Met**			**Comments/Guidelines for Review**
EVALUATION CRITERIA		**Yes**	**No**	**N/A**	
1.	All confidential and protected health information (PHI) is secure. Client records are not located where the public can view or have physical access to storage.	☐	☐	☐	
2.	Separate storage system maintains inactive medical records.	☐	☐	☐	
CATEGORY 4: MEDICATION SUPPORT SERVICES *(Psychiatry only)*		**Criteria Met**			**Comments/Guidelines for Review**
EVALUATION CRITERIA		**YES**	**NO**	**N/A**	
1.	Prescription pads are inaccessible to the public.	☐	☐	☐	
2.	Does the provider store or maintain medications on site?	☐	☐	☐	If the response is "No," indicate that in the "Criteria Met" column and skip the remaining category.
3.	**MEDICATION STORAGE** All drugs are stored in a locked area with access limited to those medical personal authorized to prescribe, dispense, or administer medication.	☐	☐	☐	Review temperature log-is it current? Check room and refrigerator thermometers to verify that they are at the appropriate temperatures.
4.	All medications are stored at proper temperatures: Room temperature medications at 59 - 86 degrees F; Refrigerated medications at 36 - 45 degrees F	☐	☐	☐	
5.	Verify that food and other items are not stored in the same refrigerator as the medications.	☐	☐	☐	No food should be stored in the same refrigerator as medications.

6.	Medications intended for external-use-only are stored separately from oral and injectable medications.	☐	☐	☐	Ask to see medications for external use only-check labels & expiration dates. Verify external medications are stored separately from oral and injectable medications.
7.	Controlled drugs (Schedule II, III, and IV) are kept separate from non-controlled drugs.	☐	☐	☐	
8.	**INCOMING (RECEIPT) MEDICATION LOG** All medications entering the facility are logged, including sample medications, prescriptions for individual patents, and house supply. For each medication, the log is maintained for one year and documents:	☐	☐	☐	
a.	Drug name;	☐	☐	☐	
b.	Strength and quantity;	☐	☐	☐	
c.	Name of patient;	☐	☐	☐	
d.	The date ordered;	☐	☐	☐	
e.	The date received and name of issuing pharmacy or drug company	☐	☐	☐	
9.	**LABELING** Medications obtained by prescription are labeled in compliance with federal and state laws, including but not limited to:	☐	☐	☐	
a.	Drug name;	☐	☐	☐	
b.	Strength and quantity;	☐	☐	☐	
c.	Name of patient;	☐	☐	☐	
d.	The date ordered;	☐	☐	☐	
e.	The date received and name of issuing pharmacy or drug company.	☐	☐	☐	
10.	**MEDICATION DISPENSING LOG** All medications dispensed are logged, regardless of source. The log includes:	☐	☐	☐	
a.	The date and time the medication was administered;	☐	☐	☐	
b.	The source of the medication;	☐	☐	☐	
C.	The lot and/or vial number if the medication was dispensed from a multi-dose container or sample	☐	☐	☐	
d.	The name of the patient receiving the medication;	☐	☐	☐	
e.	The dose of the medication given;	☐	☐	☐	
f.	The route of administration;	☐	☐	☐	
g.	The signature/licensure/unique identifying number of authorized staff who administered.	☐	☐	☐	

CATEGORY 4: MEDICATION SUPPORT SERVICES *(continued)*		Criteria Met			Comments/Guidelines for Review
EVALUATION CRITERIA		Yes	No	N/A	
11.	**AUDITING SUPPLIES OF CONTROLLED SUBSTANCES** Separate logs are maintained for Schedule II, III & IV drugs	☐	☐	☐	Verify which staff the facility has designated access to the Schedule II, III, and IV controlled drugs.
12.	For controlled substances, evidence records are reconciled at least daily and retained at least one year	☐	☐	☐	Review the current controlled substances medication log to determine if appropriate licensed staff is reconciling the log at least daily or every shift.
13.	**CONTROLLED SUBSTANCE LOGS** Does the controlled substance log include:	☐	☐	☐	Review the controlled substances medication record and verify the required information is documented. **NOTE:** If supplied as part of a unit dose medication system, it does not need to be separate from other medication records.
a.	Patient's name;	☐	☐	☐	
b.	The signature/licensure/unique identifying number of authorized staff who prescribed;	☐	☐	☐	
c.	Prescription number;	☐	☐	☐	
d.	Drug name;	☐	☐	☐	
e.	Strength;	☐	☐	☐	
f.	Dose administered;	☐	☐	☐	
g.	Date and time administered;	☐	☐	☐	
h.	The signature/licensure/unique identifying number of authorized staff who administered the drug.	☐	☐	☐	
14.	Medication disposed of after the expiration date.	☐	☐	☐	
15.	**MEDICATION DISPOSAL LOG** A medication disposal log is maintained to ensure proper disposal of expired, contaminated, deteriorated, and abandoned drugs in a manner consistem with state and federal laws. The log includes:	☐	☐	☐	
a.	The name of the patient;	☐	☐	☐	
b.	Medication name and strength;	☐	☐	☐	
c.	The prescription number;	☐	☐	☐	
d.	Amount destroyed;	☐	☐	☐	
e.	Date of destruction;	☐	☐	☐	
f.	Name and signature of witnesses.	☐	☐	☐	
16.	Evidence the medication disposal log is retained for at least three (3) years.	☐	☐	☐	

FRESNO COUNTY MENTAL HEALTH PLAN

2021 CHART REVIEW DOCUMENTATION CHECKLIST - OUTPATIENT SERVICES (Non-STRTP)

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
CONSENT FOR TREATMENT/ONSET OF TREATMENT						
1	Consent for treatment is present and appropriately executed (i.e., by client 18 and older, legal guardian, court order, Deputy Conservator) and in the record for each voluntary episode of inpatient hospitalization, voluntary crisis stabilization services and prior to starting outpatient services.					**Q**
2	There is evidence in the medical record client was offered a choice of provider.					**Q**
ASSESSMENT						
3	Client was offered Advance Directive information (Adults only).					**Q**
4	The assessment was completed in accordance with FCMHP's established standards for timeliness and frequency.					**Q**
5	**The assessment includes ALL of the following:**					**Q**
	a) **Presenting problem**; chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information.					
	b) **Relevant conditions and psychosocial factors** affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma.					
	c) **Mental Health History**; previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. Other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.					
	d) **Medical History**; relevant physical health conditions reported by the client or significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal events and relevant/significant developmental history.					
	e) **Medications**; information about medications the client has received, or is receiving, to treat MH and medical conditions, including duration of treatment. Should include the absence or presence of allergies or adverse reactions.					
	f) **Client strengths** in achieving goals related to their MH needs and functional impairments as a result of the MH diagnosis.					
	g) **Risks**; situations that present a risk to the client and/or others, including past or current trauma (e.g. suicidal/homicidal risks and grave disability are noted and updated).					
	h) **Substance exposure/substance Use**; past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs.					
	i) **A mental status examination**					
	j) **A complete, accurate diagnosis;** a diagnosis utilizing DSM 5 criteria, corresponding to the current ICD diagnosis code, and in accordance with the covered diagnoses for reimbursment of outpatient SMHS must be documented, consistent with the presenting problems, history, MSE and/or other clinical data; including any current substance use disorder diagnosis. Accounts for all sx/impairments identified in content of Assessment.					**R1**
6	The assessment includes the date of service, signature of person providing the service (or electronic equivalent), employee ID number, type of professional degree, licensure or job title, and the date the documentation was entered into the medical record. Assessment is completed by an LPHA (including registered/waivered) that was credentialed as MHP provider at the time of the assessment or within FCMHP documentation standards.					**R2**

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
7	Cultural issues (including language, gender identity, and sexual orientation) are noted in the assessment.					Q
8	Duration times (service duration, doc/travel, total), date, language, location and ICD code match what was billed in Avatar. (Recoupment of assessment activity only when assessment activity is within audit timeframe.)					R8
9	Medical record contains the MHP-required outcomes measurement tools with appropriate frequency.					Q
CLIENT PLAN (a.k.a. Treatment Plan; Plan of Care)						
10	The client plan is completed within 60 days of the assessment unless there is documentation supporting the need for more time.					R4
11	The client plan is completed on an annual basis or as specified in the MHP's documentation guidelines and is reviewed and/or updated as appropriate in response to a crisis event resulting in emergency services or whenever there is a significant change in the client's condition. (Recoupment of all services within audit timeframe not based on a current, valid client plan enacted with all planned service interventions included prior to services being delivered, except for assessment, plan development, certain TCM and ICC activities, and crisis intervention/assessment. All prior to being claimed.)					R2, R4
12	The client plan includes specific, observable, and quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the identified mental health diagnosis.					Q
13	The client plan identifies the proposed type(s) of interventions/modalities, including a detailed description of each intervention to be provided.					Q
14	The client plan includes the proposed frequency and duration of the intervention(s).					Q
15	The client plan includes interventions that focus on and address the identified functional impairments as a result of the MH disorder identified by the mental health assessment.					Q
16	Interventions are consistent with client plan goal(s)/treatment objective(s).					Q
17	The Treatment Plan is consistent with the qualifying diagnosis and need for service identified per the assessment. (Documentation must substantiate that the focus of interventions is to address the benficiary's mental health condition.)					R4
18	The client plan is signed by one of the following: The person providing the service; or the person representing a team providing the service; or the person representing a team or program providing the service; **OR**					R4
	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 co-sign: A Physician; A Licensed/Registered/Waivered Psychologist, SW, PCC, or MFT; NP or RN.					
19	The client plan includes the client's signature or the signature of the client's legal representative when: the client is expected to be in long-term treatment, as determined by the MHP, and, the client plan provides that the client will be receiving more than one type of SMHS; **OR**					Q
	In absence of a client signature, documentation of the client's participation in and agreement with the plan (e.g., Court ordered treatment; reference of participation and agreement in the body of plan; or a description of the client's participation and agreement in the medical record) and there is a written explanation why it is absent and documents ongoing attempts to obtain the appropriate signature(s).					

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
20	Documentation that the contractor/provider offered a copy of the treatment plan to the client. Documentation includes acceptance/decline.					Q
21	Cultural issues (e.g., language, culture/ethnicity) are noted in the client plan.					Q
22	For a non-English speaker, the client plan documents how the client plan was developed.					Q
23	The duration, date, ICD code, location on client plan match what has been billed in Avatar. (Recoupment if plan development activity is within the audit timeframe.)					R8
MEDICAL NECESSITY						
24	As based on the beneficiary's need for services established by a clinical assessment, the client conidition meets **all three** (25a, b, and c) **of the following medical necessity criteria listed below** (Recoupment of all services if all three not met):					R1-3
	a) A current, accurate, and complete ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract.					
	b) The client, as a result of an included ICD-10 diagnosis or emotional disturbance (listed in 25a), must have at least ONE of the following criteria (1-4 below) wich is substantiated in documentaion:					
	1. Significant impairment in an important area of life functioning; OR					
	2. Probability of significant deterioration in an important area of life functioning; OR					
	3. Probability that the child will not progress developmentally as individually appropriate; OR					
	4. For full scope Medi-cal beneficiaries under the age of 21 years, a condition as a result of the mental health disorder or emotional disturbance that SMHS can correct or ameliorate (EPSDT standard).					
	c) The proposed and actual intervention(s) meet the intervention criteria listed below:					
	1. The focus of the proposed and actual intervention(s) is to address the condition identified, or for full scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental health disorder or emotional disturbance that SMHS can correct or ameliorate.					
	2. The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (a-d) below:					
	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 Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.					
25	If the client did not meet medical necessity, an NOABD was provided to the client/family and a copy is in the chart.					Q
PROGRESS NOTES						
26	Progress notes document the following:					R2, R5-8

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
	a) Interventions applied and the client's response to the interventions. (Notes must document that the focus of the intervention is to address the beneficiary's included mental health condition and that the expectation of the intervention is that it will significantly diminish the imparment, prevent significant deterioration in an important area of life functioning, allow the child to progress develompmentally as individually appropriate, or for full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.)					
	b) The date the services were provided.					
	c) The location where services were provided.					
	d) The amount of time taken to provide services is documented on the progress note and matches claim for service.					
	e) The signature of the person(s) rendering the service (or electronic equivalent), license number or employee ID number, type of professional degree, and licensure or job title.					
27	The progress note is completed in accordance with the timeliness and frequency requirements specific to the Fresno County MHP documentation standards.					**Q**
28	Services billed to the FCMHP are consistent with the documentation in the client's record and include the following:					**R8**
	a) The date and units of time of service that match claim					
	b) The correct purpose of visit/service code of the SMHS claimed.					
	c) The name of the provider on the claim matches the name of the provider that rendered the service.					
29	There is a progress note for every service claimed by the provider.					**R8**
30	Progress note indicates service is provided in an eligible setting (not an IMD, jail, juvenile hall prior to disposition/adjudication, during day treatment program hours, or other lockout setting).					**R 9-10**
31	Progress or lack of progress toward treatment goals are documented and refer to the most recent treatment plan goals.					**Q**
32	Notes for billable service must include documentation of a valid and eligible SMHS service, even if the client was a no show or cancels appointment.					**R15**
33	Service was provided within the scope of practice of the person delivering the service.					**R16**
34	Service not solely for substance use disorder.					**R7**
35	Service provided was **not** solely for one of the following:					**R11**
	a) academic educational services					
	b) vocational services that has work or work training as its actual purpose					
	c) recreation					
	d) socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors					
	e) transportation					
	f) clerical					
	g) payee related					
36	Medical necessity for continued treatment is documented for each claimed service. The progress note decribes how the service provided reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioining, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.					**R4-7**

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
37	Evidence-based practice used and appropriately documented in text of progress note (i.e. Dialectical Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Cognitive Behavioral Therapy, Structural Family Therapy, Motivational Interviewing, etc.).					**Q**
38	Staff interventions and client response to life-threatening conditions, i.e., suicidal/homicidal ideation and grave disability are documented.					**S**
39	Evidence of collaboration and referrals to community resources or other agencies when appropriate.					**Q**
40	Discharge summary or plan for follow-up care, when appropriate, must include the reason for discharge and referral. If no referrals are provided, the reason for no referrals is documented.					**Q**
41	If the client has ceased services, there is documentation to explain follow up referrals, attempts to contact or reasons for termination.					**Q**
42	If the diagnosis has changed for any reason, and a clinical assessment was not completed, appropriate documentation with clinical justification is noted in a progress note. The clinical documentation must provide the current DSM and/or ICD-based reasoning for the diagnostic change.					**R1-3**
43	If multiple providers are concurrently treating the client, documented evidence of communication between the providers is noted in the chart.					**Q**
44	If a client had a recent 5150 episode or inpatient psychiatric hospitalization, appropriate follow up was documented and provided (e.g., Treatment plan was reviewed and updated when appropriate).					**Q**
45	The "Primary Diagnosis" selected at the time of the service is an included Medi-Cal diagnosis (for billable services only).					**R2, R7**
46	Effort to contact the client after missed appointments is documented.					**Q**
TYPE OF SERVICE CONTACT (Purpose of Visit Mental Health Services & Crisis)						
47	**103** (Assessment) notes focus on information gathering activities and determination of medical necessity.					**R8, R15**
48	**126** (Individual psychotherapy), **156** (family psychotherapy), and **83** (individual or family psychotherapy) notes show a service that focuses primarily on symptom reduction for the client even if it is a family session.					**R8, R15**
49	**82 Notes** (Group therapy) demonstrate a service that focuses on symptom reduction and is provided to multiple clients in one session. The progress note includes:					**R8, R12, R15**
	a) The group note must be individualized to speak to the specific progress of the individual client.					
	b) Time is properly apportioned to all clients present and, if applicable, to multiple providers. Group formula components included on progress note.					
50	When services are being provided to, or on behalf of, a client involving one (1) or more providers at one point in time, the progress notes or other relevant documentation in the medical record include:					**R12-13**
	a) Medical necessity for having more than one provider.					
	b) The total number of providers and their specific involvement in the context of the mental health needs of the beneficiary, with signature(s) of all person(s) providing the services.					
	c) The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable.					
	d) The total number of beneficiaries participating in the service activity.					

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
51	**150 Notes** (Collateral) show contact with the client's significant support person(s) including consultation and training to assist in better utilization of services and understanding of the client's mental illness per the MH assessment and client plan.					**R8, R15**
52	**153 Notes** (group collateral) show a service that focuses on symptom reduction and is provided to multiple significant support persons in one session. The notes must be individualized to speak to the specific progress of each client represented. Group formula is applied to number of clients represented. Group service meets criteria of Items 49(a-b) and 50(a-d) above.					**R8, R12-13, R15**
53	**158** (Individual rehab) or **85** (Group rehab) show client was offered assistance, training, counseling, support, or encouragement with mental health stated symptoms, and impairments per POC. (Group notes must be individualized to speak to the specific progress of each client represented. Group formula is applied to number of clients represented. Group service meets criteria of Items 49(a-b) and 50(a-d) above.)					**R8, R12-13, R15**
54	**159 Notes** (Plan Development) show a service activity which consists of development and approval of the client's plan, and/or monitoring of the client's progress.					**R8, R15**
55	**205 Notes** (Case management linkage and consultation) show client was linked, assisted, monitored, or advocated for by staff per the client plan (i.e., services were not for providing transportation or completing a task for the client).					**R8, R15**
	a) **205 Notes** (Case management linkage and consultation) show appropriate follow up when a referral has been made.					**R8, R15**
56	**206 Notes** (Case management placement) show client was offered assistance in locating and securing an appropriate living environment or funding per POC.					**R8, R15**
57	**31 Notes** (Crisis Intervention - Other) or **181 Notes** (Crisis Intervention - Therapy) show client's condition required (and received) a more timely response than a regularly scheduled visit and provided interventions to attempt to de-escalate the client's urgent mental health condition.					**R8, R15**
58	**180 Notes** (Crisis Intervention Assessment) show appropriate risk assessments and safety assessments to correspond with the crisis episode. Risk and safety assessments must include documentation of both risk and protective factors, collateral supports with contact information, homicidal and suicidal risk and contingency plans.					**R8, R15**
59	**127 Intensive Home Based Services Authorization** An approved MHP IHBS authorization is in the record prior to the delivery of IHBS. IHBS claims prior to date of MHP authorization will be disallowed.					**R3, R4**
60	**127 Notes** (Intensive Home-Based Services - IHBS) show a service in the home or home-like setting that is targeted to a minor client (or their significant support person) with significant intensity to address the intensive mental health needs of the child/youth consistent with the POC. The IHBS activity contains medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, **and focuses on <u>at least one</u> of the following:**					**R8, R15**
	a) Shows a service focused on development of functional skills to improve self-care, self-regulation, or other functional impairments; or					
	b) Shows a service focused on improvement of self-management of symptoms (including self-administration of medications as appropriate), or					
	c) Shows a service focused on education of child and/or caregivers about, and how to manage MH symptoms, or					
	d) Shows a service that supports the development, maintenance and use of support networks, or					

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
	e) Shows a service to address behaviors that interfere with a stable/permanent family life, or					
	f) Shows a service to address behaviors that interfere with a child/youth's success in achieving educational objectives in an academic program in the community, or					
	g) Shows a service to address behaviors that interfere with seeking and maintaining a job, or					
	h) Shows a service to address behaviors that interfere with transitional independent living objectives.					
61	**207 Notes** (Intensive Care Coordination - ICC) show a service that facilitates development and implementation of cross-system/multi-agency collaboration as described by the *Child and Family Team (CFT)* **to support the client's mental health needs per POC, and contains <u>at least one</u> of the following**:					**R8, R15**
	a) *ICC assessing activities* , to identify client/family's needs and strengths; reviewing information from family and other sources; evaluating effectiveness of previous interventions; or					
	b) *ICC service planning and implementation activities* , including developing goals of ICC Plan; ensuring active participation of CFT members; identifying interventions/course of action; or					
	c) *ICC monitoring and adapting activities* to ensure identified services and activities are progressing appropriately; or					
	d) *ICC transition activities* to foster long-term stability with effective use of natural supports and community resources.					
62	Crisis residential, crisis stabilization (one per 23 hour period), day treatment, DTI, and/or adult residential services are documented daily.					**R8, R20**
CULTURAL COMPETENCE						
63	Regarding cultural/linguistic services and availability in alternative formats and there is evidence the client is made aware that SMHS are available in their preferred language as documented by one or more of the following:					**Q**
	a) Documentation that mental health interpreter services are offered and provided, when applicable.					
	b) When the need for language assistance is identified in the assessment, there is documentation of linking clients to culturally-specific and/or linguistic services as described in the MHP's Cultural Competence Plan Requirements.					
	c) When applicable, service-related personal correspondence is provided in the client's preferred language.					
	d) When applicable, treatment specific information is provided to the client in an alternative format (e.g., braille, audio, large print, etc.).					
OVERALL QUESTIONS						
64	Non-electronic client records are legible.					**R5-7**
65	Release(s) of information present in the medical record when appropriate.					**H**
66	Mandated reporting to CPS, APS completed if necessary and documented.					**S**
67	Mandated Tarasoff notification made to law enforcement and intended victim.					**S**
68	Client signature of authorization for payment and release of information for claiming purposes located in the client record and is dated prior to services claimed (Found on CMS 1500 form lines 12 and 13 or elsewhere in chart).					**R**
MEDICATION SUPPORT SERVICES						

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
69	**170, 170T (190 for telemedicine provider) Assessment (New Patient)** Psychiatric diagnostic evaluation with medical services. Code is used by a Physician, or NP for diagnostic assessment or reassessment. **Face-to-Face**					**R8, R15**
70	**172, 172T (192 for telemedicine provider) Brief (Established Patient)** This code is used by a Physician, PA or NP, for a client with a problem focused history, a problem focused examination, with straight forward medical decisions. The presenting problem is usually self-limited or minor. **Face-to-Face**					**R8, R15**
71	**173, 173T (193 for telemedicine provier) Expanded (Regular follow up visit of Established Patient)** This code is used by a Physician, PA or NP, for a client with an expanded problem focused history, an expanded problem focused examination. The presenting problem(s) are of low to moderate severity. **Face-to-Face**					**R8, R15**
72	**40 notes** (Med refills/injection) used for meds administered by RN/LVN/LPT. Also used for nursing interventions related to medication refill needs.					**R8, R15**
73	**41, 41T notes** (Meds education/administration) focus on informing client and significant support persons about the psych meds being prescribed. May also be used for general nursing interventions such as MD consultation, MD consent (completion of the JV 220), and other nursing services which do not fall under the category of med refill/injection. Or **Code 205 -Linkage/Consultation.**					**R8, R15**
74	The Medical Progress notes document the following and match claims for billing:					**R8**
	a) The date the services were provided.					
	b) The amount of time/units to provide services is documented on the progress note and matches the claim for service.					
	c) The signature of the person providing the service, license number or employee ID number, type of professional degree, and licensure or job title.					
	d) The diagnosis on the medical progress note matches the diagnosis claimed.					
75	The provider obtained and retained a current written medication consent form signed by the client 18 years of age and older, legal guardian, court order or conservator for each medication prescribed and in accordance with timeliness and frequency standards specified in the MHP's documentation standards.					**S**
76	Medication consent for psychiatric medications include the following required elements: Reason; alternative treatments available, if any; type of medication; dosage; frequency; method of administration; duration; probable side effects; possible side effects if taken longer than 3 months; consent may be withdrawn at any time.					**S**
77	The medication consent includes: The date of service; The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title, license number; and the date the documentation was entered in the medical record.					**S**
78	Medication is appropriate for diagnosis or treatment of symptoms.					**S**
79	Medication orders: dosage, frequency, duration, route, are present in documentation.					**S**
80	Lab work ordered as required to monitor for safety concerns.					**S**
81	Abnormal Involutary Movement Scale/AIMS survey or similar is current or discussed in progress notes.					**S**
82	Compliance to medication regimen is documented.					**S**
83	Response of target symptoms to medication is documented.					**S**
84	Drug allergy is prominently documented as an alert.					**S**
85	Referral to PCP or other community resources or other agencies when appropriate.					**Q**

FCMHP Missing Documentation and Potential Disallowances Worksheet

Audit Date

Provider/Organization

Consumer Name

				Reason for Disallowance/Recoupment											
Service Date	Service	Units	Cost	Not MH or billable serv or lockout	No DOC	Incorr SVC Code	POC Issues	Dup Claim	Dur Issue	No-Show	No Med Nec/ Excl Dx	Incorr Dx, time	SVC not auth	Other	Comments

X

**Provider/Organization Representative Signature

Date

X

Utilization Review Specialist Signature

Date

Total Potential Disallowances

$

If the provider wishes to appeal any of the recoupment findings, the provider may do so by submitting a written appeal within ten (10) working days following the receipt of this worksheet. Disallowances for missing documentation not presented to reviewers while on-site may not be appealed. Please address the appeal to the attention of: Katherine M Rexroat LMFT, Clinical Supervisor, DBH Managed Care P.O. Box 45003 Fresno CA, 93718-9886; or send to mcare@co.fresno.ca.us.

**Representative signature certifies that all items listed above were discussed prior to the conclusion to the audit review.

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FRESNO COUNTY MENTAL HEALTH PLAN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Provider		Street Address, City, State, Zip Code	
Category	Summary Statement of Deficiencies	Provider's Plan of Correction	Completion Date
(The Managed Care team will enter information into this box.) This box will list the documentation standard that Medi-Cal and/or the FCMHP requires (which was found to be missing or weak in the chart review). This information is quoted from the Audit Tool Summary.	(The Managed Care team will enter information into this box.) This is box where Managed Care identifies the specific document and/or documents in the chart review that did not meet the Medi-Cal and/or FCMHP standards. If the problem is a recoupment issue, Managed Care will identify that in this box also. This information is also quoted from the Audit Tool Summary.	(The Provider will enter information into this box.) This is where the agency identifies what the agency will do or what the agency has done to make certain that in all future audits the standard(s) identified under "Category" will be in compliance with Medi-Cal and/or the FCMHP.	(The Provider will enter information into this box.) This is where the agency will document the completion date of the "Provider's Plan of Correction"
Provider's Signature*		Title	Date
*			

How to Fill-out the Plan Of Correction Form

If deficiencies are cited, an approved plan of correction is required to continue program participation.

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