FISCAL YEAR (FY) 2015/2016 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
MENDOCINO COUNTY MENTAL HEALTH PLAN REVIEW
October 26, 2015-October 29, 2015
DRAFT SYSTEM REVIEW FINDINGS REPORT

This report details the findings from the triennial system review of the Mendocino County Mental Health Plan (MHP). The report is organized according to the findings from each section of the FY2015/2016 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services (Mental Health and Substance use Disorder Services Information Notice No. 15-042), specifically Sections A-J and the Attestation. This report details the requirements deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS. 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).

For informational purposes, this draft report also includes additional information that may be useful for the MHP, including a description of calls testing compliance of the MHP's 24/7 toll-free telephone access line and a section detailing information gathered for the 12 "SURVEY ONLY" questions in the protocol.

The MHP will have thirty (30) days from receipt to review the draft report. If the MHP wishes to contest the findings of the system review and/or the chart review, it may do so, in writing, before the 30-day period concludes. If the MHP does not respond within 30 days, DHCS will then issue its Final Report. The MHP is required to submit a Plan of Correction (POC) to DHCS within sixty (60) days after receipt of the final report for all system and chart review items deemed out of compliance. The POC should include the following information:

(1) Description of corrective actions, including milestones
(2) Timeline for implementation and/or completion of corrective actions
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS

If the MHP chooses to appeal any of the out of compliance items, the MHP should submit an appeal in writing within 15 working days after receipt of the final report. A POC will still be required pending the outcome of the appeal.

Report Contents

RESULTS SUMMARY: SYSTEM REVIEW

SYSTEM REVIEW SECTION	TOTAL ITEMS REVIEWED	SURVEY ONLY ITEMS	TOTAL FINDINGS PARTIAL or OOC	PROTOCOL QUESTIONS OUT-OF-COMPLIANCE (OOC) OR PARTIAL COMPLIANCE	IN COMPLIANCE PERCENTAGE FOR SECTION
ATTESTATION	5	0	0/5		100%
SECTION A: ACCESS	48	2	0/46		100%
SECTION B: AUTHORIZATION	22	0	2/22	B1c, B5a1	91%
SECTION C: BENEFICIARY PROTECTION	25	0	0/25		100%
SECTION D: FUNDING, REPORTING & CONTRACTING REQUIREMENTS	NOT APPLICABLE				
SECTION E: NETWORK ADEQUACY AND ARRAY OF SERVICES	20	4	2/16	E8b2, E8b3	88%
SECTION F: INTERFACE WITH PHYSICAL HEALTH CARE	6	0	0/6		100%
SECTION G: PROVIDER RELATIONS	5	0	1/5	G2b	80%
SECTION H: PROGRAM INTEGRITY	20	4	1/16	H3b	94%
SECTION I: QUALITY IMPROVEMENT	31	2	0/29		100%
SECTION J: MENTAL HEALTH SERVICES ACT	17	0	2/17	J4b, J4c	88%
TOTAL ITEMS REVIEWED	199	12	8		

Overall System Review Compliance

Total Number of Requirements Reviewed	187 (with 5 Attestation items)			
Total Number of SURVEY ONLY Requirements	12 (NOT INCLUDED IN CALCULATIONS)			
Total Number of Requirements Partial or OOC	8		**OUT OF 187**	
OVERALL PERCENTAGE OF COMPLIANCE	IN (# IN/187)	96.0%	OOC/Partial (# OOC/187)	4.0%

FINDINGS

ATTESTATION

DHCS randomly selected five Attestation items to verify compliance with regulatory and/or contractual requirements. All requirements were deemed in compliance. A Plan of Correction is not required.

SECTION A: ACCESS

PROTOCOL REQUIREMENTS		
9a.	Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:	
	1) Does the MHP provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county?	
	2) Does the toll-free telephone number provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity PROTOCOL REQUIREMENTS are met?	
	3) Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?	
	4) Does the toll-free telephone number provide information to the 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 October 7, 2015, at 11:21 pm. The call was answered after three (3) rings via live operator. The operator immediately asked the DHCS test caller if he/she was in crisis. The caller responded in the negative and proceeded to request information about how to obtain SMHS. The operator then provided the caller with information about services available at the walk-in clinic, including hours of operation, location, and an explanation of the Intake and referral process. The operator provided the caller with information about how to access SMHS and the caller provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol question(s) A9a2 and A9a3.

Test Call #2 was placed on October 8, 2015, at 3:09 pm. The call was answered after one (1) ring via a live operator. The DHCS test caller requested information about SMHS. The operator explained to the caller that he/she would need to make an appointment to see a psychiatrist in order for the medication to be prescribed. The operator inquired as to the amount of medication the caller had remaining and if this was an emergency situation. The caller replied in the negative. The operator asked how the caller was feeling and the caller responded accordingly. The operator informed the caller that if he/she needed an immediate refill to go to the emergency room for urgent assistance. The operator provided several locations with addresses in which the caller could go to receive SMHS. The operator asked the caller for insurance information and the caller informed the operator that he/she had Medi-Cal. The caller was provided information about how to access SMHS and the operator

provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol question(s) A9a2 and A9a3.

Test Call #3 was placed on October 12, 2015, at 10:51 pm. The call was answered after two (2) rings via a live operator. The operator immediately asked the DHCS test caller if he/she was in crisis and in a safe place. The caller replied in the negative regarding being in crisis and acknowledged that he/she was in a safe place. The operator advised the caller that there was staff available 24/7 for crisis situations. The caller proceeded to request information about how to obtain SMHS. The operator then provided the caller with information about services available at the walk-in clinic, including hours of operation, location, and an explanation of the Intake and referral process. The operator provided the caller with information about how to access SMHS and the caller provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol question(s) A9a2 and A9a3.

Test Call #4 was placed on October 14, 2015, at 4:25 pm. The call was answered after five (5) rings via a live operator. The DHCS test caller requested information about SMHS for anxiety medication. The operator asked the caller if he/she was in crisis and the caller replied in the negative. The operator asked for the caller's phone number and Medi-Cal information. The operator explained that they handled severe mental illness and psychiatric care at their location. The operator presented to mail the provider list to the caller. The operator presented three locations to obtain SMHS. The operator informed the caller that he/she could go to the emergency room and bring prescription bottle(s). The caller was provided information about how to access SMHS and the caller was provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol question(s) A9a2 and A9a3.

Test Call #5 was placed on October 16, 2015, at 7:24 am. The call was answered after one (1) ring via a live operator. The DHCS test caller requested information about SMHS. The operator asked the caller if he/she was in crisis or had any suicidal thoughts or thoughts of hurting him/her self. The caller replied in the negative. The operator asked the caller if he/she had any diagnosis from a doctor for depression and the caller replied in the negative. The operator informed the caller that he/she could make an appointment with a therapist to get an assessment and the operator provided the caller with a telephone number. The caller informed the operator that he/she would call back for the appointment. The operator voiced concern about the caller and advised the caller that he/she could call the 24/7 telephone line if the caller needed to talk. The caller was provided information about how to access SMHS and the caller was provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol question(s) A9a2 and A9a3.

Test Call #6 was placed on October 19, 2015 at 7:48 am. The call was answered after one (1) ring via a live operator. The DHCS test caller requested information about SMHS. The operator asked if the caller was in crisis and the caller replied in the negative. The operator informed the caller that he/she could go to the emergency room or call 911 if in crisis. The operator confirmed the caller's preferred language. The operator asked the caller to provide

his/her name and asked if the caller had Medi-Cal. The caller presented his/her name and explained that he/she did not have the requested Medi-Cal information. The operator asked if the caller would be transferring his/her Medi-Cal to the county and the caller replied in the affirmative. The caller was then provided information about how to access SMHS and was provided the clinic location, business hours, telephone number and landmarks. The caller was informed that the access center was available 24/7. The operator presented to mail the provider list to the caller and he/she declined the offer. The caller was provided information about how to access SMHS and the caller was provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol question(s) A9a2 and A9a3.

Test Call #7 was placed on October 20, 2015, at 2:15 pm. The call was answered after two (2) rings via a live operator. The operator confirmed the callers preferred language. The caller explained that he/she was not happy with the services received and was requesting information on how to file a complaint. The operator told the caller that he/she had the right to file a complaint and presented several ways a complaint could be filed. The operator provided several departments and telephone numbers and informed the caller of the grievance process. The operator presented to mail the provider list to the caller and informed the caller that he/she could choose another provider on the list. The caller was provided information on how to how to use the problem resolution and fair hearing processes. The call is deemed in compliance with the regulatory requirements for protocol question(s) A9a4.

FINDINGS

Test Call Results Summary

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	In	In	In	In	IN	In	N/A	100%
9a-3	In	In	In	In	IN	In	N/A	100%
9a-4	N/A	N/A	N/A	N/A	N/A	N/A	In	100%

PLAN OF CORRECTION

All requirements were deemed in compliance. A Plan of Correction is not required.

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SECTION B: AUTHORIZATION

PROTOCOL REQUIREMENTS	
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)*	

FINDINGS

The MHP did not furnish evidence it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services. DHCS reviewed the MHP's

policy and procedure (P&P) III.C-23: Point of Authorization. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP did not approve or deny TARs within 14 calendar days of the receipt of the TAR in accordance with title 9 regulations. In addition, DHCS inspected a sample of 100 TARs to verify compliance with regulatory requirements. The TAR sample review findings are detailed below:

	PROTOCOL REQUIREMENT	# TARS IN COMPLIANCE	# TARs OOC	COMPLIANCE PERCENTAGE
1c	TARs approves or denied within 14 calendar days	99	1	99%

Protocol question(s) B1c is deemed in partial compliance.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) are met for the approval or denial of TARs within 14 calendar days of the receipt of the TAR and denial by a physician in accordance with title 9 regulations.

PROTOCOL REQUIREMENTS	
5.	Regarding Notices of Action (NOAs):
5a.	1) NOA-A: Is the MHP providing a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible to any SMHS?
	2) Does the MHP provide for a second opinion from a qualified health care professional within the MHP network or arrange for the beneficiary to obtain a second opinion outside the MHP network, at no cost to the beneficiary?
• *CFR, title 42, sections 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* • *CFR, title 42, section 438.206(b)(3)* • *CCR, title 9, chapter 11, section 1810.405(e)*

FINDINGS

The MHP did not furnish evidence it provides a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible to any SMHS. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: sample of a NOA-A. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the NOA-A did not have reasons checked. Protocol question(s) B5a1 is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible to any SMHS.

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SECTION E: NETWORK ADEQUACY AND ARRAY OF SERVICES

PROTOCOL REQUIREMENTS	
8.	Does the assessment include:
8b.	1) The strengths and limitations of the County and service providers that impact their ability to meet the needs of racially and ethnically diverse populations?
	2) Bilingual proficiency in threshold languages?
	3) Percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served?
• *CCR, title 9, chapter 14, section 3650(5)*	

FINDINGS

The MHP did not furnish evidence it conducts an assessment of its capacity to implement the proposed MHSA programs/services. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P III.C.10: MHSA, MHSA Plan and MHSA Schedule. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHSA plan is not clear on bilingual proficiency in threshold languages and percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served. Protocol question(s) E8b2 and E8b3 are deemed OOC.

PLAN OF CORRECTION

The MHP must 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 conducts an assessment of its capacity to implement the proposed MHSA programs/services.

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SECTION G: PROVIDER RELATIONS

PROTOCOL REQUIREMENTS	
2.	Regarding the MHP's ongoing monitoring of county-owned and operated and contracted organizational providers:
2b.	Is there evidence the MHP's monitoring system is effective?
• *CCR, title 9, chapter 11, section 1810.435 (d)(1)*	• *MHP Contract, Exhibit A, Attachment I*

FINDINGS

The MHP did not furnish evidence it has an ongoing and effective monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified per title 9 regulations. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Access Log and DHCS Overdue Provider Report. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the Access Log contains a provider that was overdue.

In addition, DHCS reviewed its Online Provider System (OPS) and generated an Overdue Provider Report which indicated the MHP has a provider overdue for certification and/or re-certification. The table below summarizes the report findings:

TOTAL ACTIVE PROVIDERS (per OPS)	NUMBER OF OVERDUE PROVIDERS (at the time of the Review)	COMPLIANCE PERCENTAGE
41	1	98%

Protocol question(s) G2b is deemed in partial compliance.

PLAN OF CORRECTION

The MHP must 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 has an ongoing and effective monitoring system in place that ensures ongoing monitoring of county-owned and operated and contracted organizational providers contracted per title 9 regulations.

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SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS	
3.	Regarding verification of services:
3b.	When unable to verify services were furnished to beneficiaries, does the MHP have a mechanism in place to ensure appropriate actions are taken?
• *CFR, title 42, sections 455.1(a)(2) and 455.20 (a)* • *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*	• *Social Security Act, Subpart A, Sections 1902(a)(4), 1903(i)(2) and 1909*

FINDINGS

The MHP did not furnish evidence it has a method to verify whether services reimbursed by Medicaid were actually furnished to the beneficiaries and, if unable to verify services, a mechanism to ensure appropriate actions are taken. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Process and Procedure III.C-25: Verification of Services. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the process and procedure III.C-25: Verification of Services does not provide steps about outreach to provider if letter was returned. Protocol question(s) H3b is deemed OOC.

PLAN OF CORRECTION

The MHP must 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 has a method to verify whether services reimbursed by Medicaid were actually furnished to the beneficiaries and, if unable to verify services, a mechanism to ensure appropriate actions are taken.

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SECTION J: MENTAL HEALTH SERVICES (MHSA)

PROTOCOL REQUIREMENTS	
4.	Regarding Full Service Partnerships (FSP):
4b.	Does the County ensure the PSC/Case Manager is responsible for developing an Individual Services and Supports Plan (ISSP) with the client and, when appropriate, the client's family?
4c.	Does the County ensure the PSC/Case Manager is culturally and linguistically competent or, at a minimum, is educated and trained in linguistic and cultural competence and has knowledge of available resources within the client/family's racial/ethnic community?
• *CCR, title 9, chapter 14, section 3620*	

FINDINGS

The County did not furnish evidence its PSC/Case Managers are responsible for developing an ISSP with the client and, when appropriate, the client's family are available to respond to the client/family 24 hours a day, 7 days a week to provide after-hours interventions. The County does not ensure its PSC/Case Managers assigned to FSP clients are culturally and linguistically competent or, at a minimum, educated and trained in linguistic and cultural competence and have knowledge of available resources within the client/family's racial/ethnic community. DHCS reviewed the following documentation presented by the County as evidence of compliance: ISSP, III.A-8-Enrollment in Full Service Partnership, III.C-10-MHSA Program, Duty Statement and Training Plan. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the 25 and under duty statement should make clear that the case manager should be responsible for developing an ISSP, and there were no tracking logs regarding if the PSC/Case Manager is culturally and linguistically competent and educated and trained in linguistic and cultural competence and have knowledge of available resources within the client/family's racial/ethnic community. Protocol question(s) J4b and J4c are deemed OOC.

PLAN OF CORRECTION

The County must submit a POC addressing the OOC findings for these requirements. The County is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its PSC/Case Managers are responsible for developing an ISSP with the client and, when appropriate, the client's family and available to respond to the client/family 24 hours a day, 7 days a week to provide after-hours interventions. The County does not ensure its PSC/Case Managers assigned to FSP clients are culturally and linguistically competent or, at a minimum, educated and trained in linguistic and cultural competence and have knowledge of available resources within the client/family's racial/ethnic community.

SURVEY ONLY FINDINGS

SECTION A: ACCESS

PROTOCOL REQUIREMENTS	
5.	Regarding written materials:
5e.	Does the MHP have a mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and/or culturally appropriate field testing)?
• *CFR, title 42, section 438.10(d)(i),(ii)* • *CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410(e)(4)*	• *CFR, title 42, section 438.10(d)(2)* • *MHP Contract, Exhibit A, Attachment I*

SURVEY FINDING

DHCS reviewed the following documentation presented by the MHP for this survey item: P&P III.A-2: Written Material in Threshold Languages. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
11.	Has the MHP updated its Cultural Competence Plan (CCP) annually in accordance with regulations?
• *CCR title 9, section 1810.410*	• *DMH Information Notice 10-02 and 10-17*

SURVEY FINDING

The MHP furnished evidence it has updated its CCP annually in accordance with regulations.

SUGGESTED ACTIONS

No further action required at this time.

Please Note: DHCS intends to issue an Information Notice to provide MHPs with guidance for developing an updated CCP. In the meantime, MHPs are required to update the existing version of the plan on an annual basis. For technical assistance in completing your annual updated, please contact your County Support Liaison.

SECTION E: NETWORK ADEQUACY AND ARRAY OF SERVICES

PROTOCOL REQUIREMENTS	
9.	Regarding the MHP's implementation of the Katie A Settlement Agreement:
9a.	Does the MHP have a mechanism in place to ensure appropriate identification of Katie A subclass members?
9b.	How does the MHP ensure active participation of children/youth and their families in Child and Family Team (CFT) meetings?
9c.	Does the MHP have a mechanism to assess its capacity to serve subclass members currently in the system?
9d.	Does the MHP have a mechanism to ensure Katie A eligibility screening is incorporated into screening, referral and assessment processes?
• *Katie A Settlement Agreement* • *Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care for Katie A Subclass Members*	

SURVEY FINDING

DHCS reviewed the following documentation presented by the MHP for this survey item: P&P III.E-1: Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), Referral, Screening tool, Consent form, and Katie A tracking log; and, a packet of Katie A forms, sign in sheets, and meeting minutes. The documentation provides sufficient evidence of compliance with State requirements.

SUGGESTED ACTIONS

No further action required at this time.

SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS		
5a.	Does the MHP ensure the following requirements are met:	
	3) Is there evidence that the MHP has a process in place to verify new and current (prior to contracting with and periodically) providers and contractors are not in the Social Security Administration's Death Master File?	
	4) Is there evidence that the MHP has a process in place to verify the accuracy of new and current (prior to contracting with and periodically) providers and contractors in the National Plan and Provider Enumeration System (NPPES)?	
	5) Is there evidence the MHP has a process in place to verify new and current (prior to contracting with and periodically) providers and contractors are not in the Excluded Parties List System (EPLS)?	
• *CFR, title 42, sections 438.214(d), 438.610, 455.400-455.470, 455.436(b)*		• *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*
• *DMH Letter No. 10-05*		

SURVEY FINDING

DHCS reviewed the following documentation presented by the MHP for this survey item: P&P III.A-9:Staffing Verification, Monthly clinical verification reports, OMG report, NPI license check log. The documentation lacks specific elements to demonstrate compliance with federal and/or State requirements. Specifically, the MHP has no process in place to verify new and current (prior to contracting with the periodically) providers and contractors are not in the Social Security Administration's Death Master File.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: The MHP to perform some research on the cost of accessing Social Security Administration's Death Master File.

PROTOCOL REQUIREMENTS	
6.	Does the MHP confirm that providers' licenses have not expired and there are no current limitations on the providers' licenses?
• *CFR, title 42, section 455.412*	

SURVEY FINDING

DHCS reviewed the following documentation presented by the MHP for this survey item: Policy and Procedure III.A-9: Staffing Verification; III.A-10-Credentialing; and Re-Credentialing, Monthly clinical verification list. The documentation lacks specific elements to

demonstrate compliance with federal and/or State requirements. Specifically, the MHP policy does not address limitations on providers' licenses.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: The MHP should add language regarding reviewing current limitations on the provider's licenses.

SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
3b.	Does the MHP have a policy and procedure in place regarding the monitoring of psychotropic medication use, including monitoring psychotropic medication use for children/youth?
3c.	If a quality of care concern or an outlier is identified related to psychotropic medication use, is there evidence the MHP took appropriate action to address the concern?
• *MHP Contract, Exhibit A, Attachment I*	

SURVEY FINDING

DHCS reviewed the following documentation presented by the MHP for this survey item: I.B-1-Psychotropic Medication Guidelines, Medication monitoring checklist. The documentation provides sufficient evidence of compliance with federal and/or State requirements.

SUGGESTED ACTIONS

No further action required at this time.

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MENDOCINO COUNTY MENTAL HEALTH PLAN REVIEW
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DRAFT FINDINGS 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; adherence to the terms of the contract between the Mendocino 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 **563** claims submitted for the months of July, August, and September of 2014.

Contents

COMPLIANCE RATING BY PERCENTAGE

NAME OF MHP: MENDOCINO

PERIOD REVIEWED: OCTOBER 26 - 29, 2015

		% In Compliance	% Out of Compliance
OVERALL COMPLIANCE			
Total Number of Claims Reviewed	563		
Total Number of Claims ***ALLOWED***	398	70.7%	
Total Number of Claims ***DISALLOWED***	165		29.3%
MEDICAL NECESSITY			
Total Number of Records Reviewed for Medical Neccessity	10		
Number of Records that ***MET*** medical necessity criteria	10	100.0%	
Number of Records that ***DID NOT MEET*** Medical Necessity	0		0.0%
For diagnosis, Impairment and Interventions proposed			
ASSESSMENT			
12 Assessments reviewed for 10 required elements			
110 of 120 required elements were **present** in the sample		91.7%	
10 of 120 elements were **missing**			8.3%
Reviewed for ALL the Required Elements of an Assessment			
MEDICATION CONSENT			
4 med consents reviewed for 14 required elements			
23 of 56 required elements were **present** in the sample		41.1%	
33 of 56 elements were **missing**			58.9%
Reviewed for ALL of the Required Elementsof a Medication Consent			
CLIENT PLAN			
12 Client Plans reviewed for 10 required elements			
112 of 120 required elements were **present** in the sample		93.3%	
8 of 120 elements were **missing**			6.7%
Reviewed for ALL the Required Elements of a Client Plan			
PROGRESS NOTES			
563 progress notes reviewed for 6 required elements			
3211 of 3378 required elements were **present** in the sample		95.1%	
167 of 3378 elements were **missing**			4.9%
Reviewed for ALL the Required Elements of a Progress Note i.e date, time, title, response etc.			
CULTURAL COMPETENCY/ALTERNATIVE FORMAT			
Total Number of medical records with Cultural/Alternative Format Needs	0		
Number of medical records that ***MET*** requirements	0	na	
Number of medical records that ***DID NOT MEET*** requirements	0		na
Reviewed for ALL the elements of Cultural Competency and Alternative Format			
DAY TREATMENT INTENSIVE/REHAB			
Number of Claims involving Day Programs	1		
Number of Day Program Claims that ***MET*** requirements	1	100.0%	
Number of Day Program Claims that ***DID NOT MEET*** requirements	0		0.0%
Reviewed for ALL Required Elements of Day program i.e components, hours, ratios etc.			

Medical Necessity

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

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

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

RR1. Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

RR2. Documentation in the medical record does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the identified functional impairments.

RR3. Documentation in the medical record does not establish that the focus of the proposed intervention is to address the functional impairment identified in CCR, title 9, chapter 11, section 1830.205(b)(2)

RR4. Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:
a) Significantly diminish the impairment;
b) Prevent significant deterioration in an important area of life functioning;
c) Allow the child to progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

FINDING 1c-1:

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

- **Line number 4. RR3, refer to Recoupment Summary for details**

PLAN OF CORRECTION 1c-1:

The MHP shall submit a 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:

The medical record associated with the following Line numbers did not meet the medical necessity criteria since there was no expectation that the documented intervention would meet the intervention criteria as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4):

- **Line numbers 2, 3, 4, 5 and 8. RR4, refer to Recoupment Summary for details**

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).

Assessment *(**Findings in this area do not result in disallowances. Plan of Correction only.**)*

	PROTOCOL REQUIREMENTS
2b.	Do the Assessments include the areas specified in the MHP Contract with the Department? 1) Presenting Problem. The beneficiary's chief complaint, history of presenting problem(s) including current level of functioning, relevant family history and current family information;
	2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health including, as applicable; living 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 must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications;
	6) Substance Exposure/Substance 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 Diagnosis; A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 2b:

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

1) Risks: **Line number 7.**

PLAN OF CORRECTION 2b:

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.

Medication Consent *(Findings in this area do not result in disallowances. Plan of Correction only.)*

PROTOCOL REQUIREMENTS	
3.	Regarding medication consent forms:
3a.	Did the provider obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication?
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 3a:

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

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 number 7**: 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.*

PLAN OF CORRECTION 3a:

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 MHP's written documentation standards.

PROTOCOL REQUIREMENTS		
3b.	Does the medication consent for psychiatric medications include the following required elements: 1) The reasons for taking such medications?	
	2) Reasonable alternative treatments available, if any?	
	3) Type of medication?	
	4) Range of frequency (of administration)?	
	5) Dosage?	
	6) Method of administration?	
	7) Duration of taking the medication?	
	8) Probable side effects?	
	9) Possible side effects if taken longer than 3 months?	
	10) Consent once given may be withdrawn at any time?	
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*		• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 3b:

Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented on the medication consent forms found in the beneficiary's medical record:

1) The reason for taking each medication: **Line number 3**

2) Reasonable alternative treatments available, if any: **Line numbers 1 and 3**

3) Type of medication: **Line number 1**

4) Range of frequency: **Line numbers 1, 3, and 10**

5) Dosage: **Line numbers 1 and 3**

6) Method of administration (oral or injection): **Line numbers 1, 3 and 10**

7) Duration of taking each medication: **Line numbers 1, 3 and 10**

8) Probable side effects: **Line numbers 1 and 3**

9) Possible side effects if taken longer than 3 months: **Line numbers 1 and 3**

10) Consent once given may be withdrawn at any time: **Line numbers 1, 3 and 10**

PLAN OF CORRECTION 3b:

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.

Client Plans

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

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

RR6. The client plan was not completed, at least, on an annual basis or as specified in the MHP's documentation guidelines.

FINDING 4a-2:

The client plan was not updated at least annually or when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards):

- **Line number 9**: 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.

PLAN OF CORRECTION 4a-2:

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) Provide evidence that all services claimed outside of the audit review period for which no client plan was in effect are disallowed.

PROTOCOL REQUIREMENTS		
4b.	Does the client plan include the items specified in the MHP Contract with the Department?	
	1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.	
	2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.	
	3) The proposed frequency of intervention(s).	
	4) The proposed duration of intervention(s).	
	5) Interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.	
	6) Interventions are consistent with client plan goal(s)/treatment objective(s).	
	7) Be consistent with the qualifying diagnoses.	
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*		• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

FINDING 4b:

The following Line numbers had client plans that did not include all of the items specified in the MHP Contract with the Department:

4b-1) One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis.

- **Line numbers 3 and 7**

4b-2) One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan (e.g. "Medication Support Services," "Targeted Case Management," "Mental Health Services," etc.).

- **Line numbers 3, 7 and 8**

4b-7) One or more client plans were not consistent with the qualifying diagnosis.

- **Line number 8**

PLAN OF CORRECTION 4b:

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 client plans are consistent with the qualifying diagnosis.

PROTOCOL REQUIREMENTS		
4e.	Is there documentation that the contractor offered a copy of the client plan to the beneficiary?	
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*		• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

FINDING 4e:

There was no documentation that the beneficiary or legal guardian was offered a copy of the client plan for the following line number :

- **Line number 3**

PLAN OF CORRECTION 4e:

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

1) Ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan.
2) Submit evidence that the MHP has an established process to ensure that the beneficiary is offered a copy of the client plan and whether or not he/she received a copy of the client plan.

PROTOCOL REQUIREMENTS		
4f.	Does the client plan include: 1) The date of service; 2) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title; AND 3) The date the documentation was entered in the medical record?	
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*		• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

FINDING 4f:

The Client plan did not include:

Signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title:

- **Line number 3**

PLAN OF CORRECTION 4f:

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

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

Progress Notes

PROTOCOL REQUIREMENTS		
5a.	Do the progress notes document the following: 1) Timely documentation (as determined by the MHP) of relevant aspects of client care, including documentation of medical necessity?	
	2) Documentation of beneficiary encounters, including relevant clinical 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?	
	2) Documentation of referrals to community resources and other agencies, when appropriate?	
	3) Documentation of follow-up care or, as appropriate, a discharge summary?	
	4) The amount of time taken to provide services?	
	5) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?	
• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*		• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

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

RR1. Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

RR2. Documentation in the medical record does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the identified functional impairments.

RR3. Documentation in the medical record does not establish that the focus of the proposed intervention is to address the functional impairment identified in CCR, title 9, chapter 11, section 1830.205(b)(2)

RR4. Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:
a) Significantly diminish the impairment;
b) Prevent significant deterioration in an important area of life functioning;
c) Allow the child to progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

RR9. No progress note was found for service claimed.

RR10. The time claimed was greater than the time documented.

RR13 The progress note indicates that the service provided was solely for one of the following:

a) Academic educational service;
b) Vocational service that has work or work training as its actual purpose;
c) Recreation; or
d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.

RR15. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

RR16. The progress note indicates the service provided was solely transportation.

RR17. The progress note indicates the service provided was solely clerical.

RR18. The progress note indicates the service provided was solely payee related.

RR19a. No service was provided.

RR19b. The service was claimed for a provider on the Office of Inspector General List of Excluded Individuals and Entities.

RR19c. The service was claimed for a provider on the Medi-Cal suspended and ineligible provider list

RR19d. The service was not provided within the scope of practice of the person delivering the service.

FINDING 5a:

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

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

5a-1) **Line numbers 3, 6 and 7**: 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). **RR3, RR4, RR9, refer to Recoupment Summary for details.**

5a-8) **Line number 7**: The provider's professional degree, licensure or job title.

- Appointment was missed or cancelled: **Line number 1. RR19a, refer to Recoupment Summary for details.**

PLEASE NOTE:
The exact same verbiage was recorded on multiple progress notes, and therefore those progress notes were not individualized, did not accurately document the beneficiary's response and the specific interventions applied, as specified in the MHP Contract with the Department for:

- **Line numbers 2, 4, 5 and 8**

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) 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.
3) The MHP shall submit a POC that indicates how the MHP will ensure that progress notes document:

   5a-1) The provider's/providers' professional degree, licensure or job title.
4) The documentation is individualized for each service provided.
5) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning.
6) 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).

FINDING 5a3:

The progress note(s) for the following Line number (s) indicate that the service provided was solely for:

- Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors: **Line number 4. RR13d, refer to Recoupment Summary for details.**

- Clerical: **Line number 7. RR17, refer to Recoupment Summary for details.**

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 academic/education services, vocational services, recreation or socialization that consists of generalized group activities that do not provide systematic, individualized feedback to the specific targeted behaviors,
3) Services provided and claimed are not solely transportation, clerical or payee related.
4) 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).

PROTOCOL REQUIREMENTS		
5c.	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 (clinical summary) B. Day rehabilitation C. Adult residential	
• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*		• *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

FINDING 5c:

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

- **Line numbers 3, 6 and 7**: There was no progress note in the medical record for the services claimed. **RR9, refer to Recoupment Summary for details.**

  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.

PLAN OF CORRECTION 5c:

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

1) Ensure that all specialty mental health services (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).
2) Ensure that all progress notes are:
   a) Accurate and meet the documentation requirements described in the MHP Contract with the Department.
   b) Indicate the type of service, the date the service was provided and the amount of time taken to provide the service as specified in the MHP Contract with the Department.
   c) Completed within the timeline and frequency specified in the MHP Contract with the Department.
   d) Legible in order to determine that the claimed mental health services were actually provided.

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

FINDING 5d:

The Progress note did not include:

- Signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title: **Line number 7**

PLAN OF CORRECTION 5d:

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

1) Ensure that all documentation includes The signature or (electronic equivalent) with the professional degree, licensure or title of the person providing the service.
2) Ensure all services claimed are provided by the appropriate and qualified staff within his or her scope of practice, if professional licensure is required for the service.

3) Ensure that staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.
4) Ensure that services are not claimed when services are provided by staff outside the staff's scope of practice or qualifications.
5) Provide evidence that all claims in which the staff was not qualified to provide services were disallowed.