StaState of California—Health and Human Services Agency

Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.

August 12, 2016

FINAL REPORT

Return Receipt Requested

Dennis P. Koch, MPA, Behavioral Health Director
Madera County Behavioral Health Services
P.O. Box 1288
Madera, CA 93639-1288

Dear Mr. Koch:

The Department of Health Care Services (DHCS) Program Oversight and Compliance Branch (POCB) conducted its triennial onsite review of Madera County's Mental Health Plan (MHP) on November 16-19, 2015. The review team utilized the FY2015/2016 Annual Review Protocol for Consolidated Specialty Mental Health Services and other Funded Services (Mental Health & Substance Use Disorder Services Information Notice No.15-042) to conduct the system and chart review. In accordance with oversight authority contained in the California Code of Regulations, title 9, chapter 11, section 1810.380, POCB reviewed the program and fiscal operations of the MHP to verify that medically necessary services were provided in compliance with State and Federal laws and regulations and/or the terms of the contract between DHCS and the MHP.

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

1. The "Draft System Review Findings Report" specifies the partial or out of compliance findings, as well as any required Plans of Correction (POC), for all system review items (Sections A-J and the Attestation) in the protocol.
2. The "Draft Chart Review Findings Report" specifies the out of compliance findings, as well as any required POC, for all chart review items (Section K) in the protocol.
3. The "Chart Compliance Summary Metrics Report" provides an overview of the compliance ratings for each of the chart review components.
4. The "Recoupment Summary" details the disallowed claims and amounts to be recouped. PLEASE NOTE: As a result of the chart review findings, DHCS is disallowing claims and recouping funds in the amount of **$5,503.77.**

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

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

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

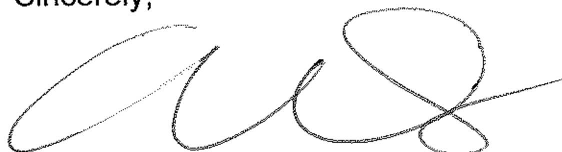
If the MHP wishes to appeal any of the out-of-compliance findings from the final report, the MHP may do so by submitting an appeal, in writing, within fifteen (15) working days after receipt of the final report. Please address the appeal to the attention of:

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

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

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

Sincerely,



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

Martine Carlton
Chief, Clinical Review and Chart Audits
Program Oversight and Compliance Branch
Mental Health Services Division
Department of Health Care Services

cc: Dina Kokkos-Gonzales, Chief, Mental Health Services Division (MHSD)
Lanette Castleman, Chief, Program Oversight and Compliance Branch, MHSD
Erika Cristo, Chief, Program Policy and Quality Assurance Branch, MHSD
John Lessley, Chief, Quality Assurance Section, Program Policy and Quality Assurance Branch, MHSD
Shelly Halpain, Administrative Support, Quality Assurance Section, Program Policy and Quality Assurance Branch, MHSD

FISCAL YEAR (FY) 2015/2016 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
MADERA COUNTY MENTAL HEALTH PLAN REVIEW
November 16 – 19, 2015
FINAL SYSTEM REVIEW FINDINGS REPORT

This report details the findings from the triennial system review of the **Madera 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.

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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	N/A	100%
SECTION A: ACCESS	48	2	8/46	A9a2, A9a3, A9a4, A10b1, A10b2, A10b3, A13a2, A13b	83%
SECTION B: AUTHORIZATION	22	0	4/22	B1c, B3a1, B5b, B5d	82%
SECTION C: BENEFICIARY PROTECTION	25	0	6/25	C3a1, C4a1, C4a2, C5b, C6, C7	76%
SECTION D: FUNDING, REPORTING & CONTRACTING REQUIREMENTS	NOT APPLICABLE				
SECTION E: NETWORK ADEQUACY AND ARRAY OF SERVICES	20	4	0/16	N/A	100%
SECTION F: INTERFACE WITH PHYSICAL HEALTH CARE	6	0	0/6	N/A	100%
SECTION G: PROVIDER RELATIONS	5	0	2/5	G3a, G3b	60%
SECTION H: PROGRAM INTEGRITY	20	4	1/16	H4	94%
SECTION I: QUALITY IMPROVEMENT	31	2	0/29	N/A	100%
SECTION J: MENTAL HEALTH SERVICES ACT	17	0	0/17	N/A	100%
TOTAL ITEMS REVIEWED	199	12	21		

Overall System Review Compliance

Total Number of Requirements Reviewed	199 (with 5 Attestation items)			
Total Number of SURVEY ONLY Requirements	12 (NOT INCLUDED IN CALCULATIONS)			
Total Number of Requirements Partial or OOC	**21**		**OUT OF 187**	
OVERALL PERCENTAGE OF COMPLIANCE	**IN** (# IN/187)	89%	**OOC/Partial** (# OOC/187)	11%

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.

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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 15, 2015 at 7:34am. The call was immediately answered by a recorded message for Madera County Behavioral Health. The recorded message was stated in both English and Spanish. The message instructed the caller to dial 911 for an emergency or to push 1 to connect to a crisis worker. For inquiries about appointments or access, the message instructed the caller to call back between the hours of 8am and 5pm. The caller was not provided with information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, or information about how to use the beneficiary problem resolution and fair hearing processes. The caller was provided with an option to connect to a crisis worker by navigating the phone tree, so this element of the call is deemed in compliance. The call is deemed OOC with the regulatory requirements for protocol question(s) A9a2 and A9a4.

Test Call #2 was placed on October 21, 2015 at 7:34am. The call was initially answered by a recorded message for Madera County Behavioral Health. The recorded message was stated in both English and Spanish. The message instructed the caller to dial 911 for an emergency or to push 1 to connect to a crisis worker. For inquiries about appointments or access, the message instructed the caller to call back between the hours of 8am and 5pm. The caller was not provided with information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, or information about how to use the beneficiary problem resolution and fair hearing processes. The caller was provided with an option to

connect to a crisis worker by navigating the phone tree, so this element of the call is deemed in compliance. The call is deemed OOC with the regulatory requirements for protocol question(s) A9a2 and A9a4.

Test Call #3 was placed on October 30, 2015 at 7:49am. The call was initially answered by a recorded message for Madera County Behavioral Health. The recorded message was stated in both English and Spanish. The message instructed the caller to dial 911 for an emergency or to push 1 to connect to a crisis worker. For inquiries about appointments or access, the message instructed the caller to call back between the hours of 8am and 5pm. The caller was not provided with information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, or information about how to use the beneficiary problem resolution and fair hearing processes. The caller was provided with an option to connect to a crisis worker by navigating the phone tree, so this element of the call is deemed in compliance. The call is deemed OOC with the regulatory requirements for protocol question(s) A9a2 and A9a4.

Test Call #4 was placed on October 31, 2015 at 3:25pm. The call was initially answered by a recorded message for Madera County Behavioral Health. The recorded message was stated in both English and Spanish. The message instructed the caller to dial 911 for an emergency or to push 1 to connect to a crisis worker. For inquiries about appointments or access, the message instructed the caller to call back between the hours of 8am and 5pm. The caller was not provided with information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, or information about how to use the beneficiary problem resolution and fair hearing processes. The caller was provided with an option to connect to a crisis worker by navigating the phone tree, so this element of the call is deemed in compliance. The call is deemed OOC with the regulatory requirements for protocol question(s) A9a2 and A9a4.

Test Call #5 was placed on November 2, 2015 at 10:25am. The call was answered after two (2) rings via live operator. The DHCS test caller stated that he/she had just signed up for Medi-Cal in the county and would like to receive help for depression. The operator inquired if the caller had previously received services with the MHP and the caller responded in the negative. The operator asked for the caller's residence information and subsequently provided the caller with telephone information for a clinic near the caller's residence. The operator did not provide the address, hours of operation or information about the availability of walk-in services. The operator provided minimal information about how to access SMHS. However, the operator did not provide any information to the caller about services needed to treat a beneficiary's urgent condition as no questions were asked of the caller about the current status of his/her condition. The call is deemed in compliance with regulatory requirements for protocol question A9a2 and OOC with requirements for protocol question A9a3.

Test Call #6 was placed on November 2, 2015 at 10:25am.The call was answered after two (2) rings via live operator. The DHCS test caller requested information about how to file a grievance concerning mental health services. The operator provided the caller with information about how to access grievance forms in the clinic lobby. The operator also attempted to transfer the caller to the Patient's Rights Advocate for further assistance. The caller was provided with information about how to use the beneficiary problem resolution and

fair hearing processes. The call is deemed in compliance with regulatory requirements for protocol question(s) A9a4.

Test Call #7 was placed on November 9, 2015 at 2:23pm.The call was answered after one (1) ring via live operator. The DHCS test caller requested information about how to access mental health services in the county. The operator transferred the call to another MHP employee; however, the caller reached a voicemail message. The call did not re-connect to the live operator. The caller was not provided with information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, or information about services needed to treat a beneficiary's urgent condition. The call is deemed OOC with regulatory requirements for protocol question(s) A9a2 and A9a3.

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	N/A
9a-2	OOC	OOC	OOC	OOC	IN	N/A	OOC	**17%**
9a-3	IN	IN	IN	IN	OOC	N/A	OOC	**66%**
9a-4	OOC	OOC	OOC	OOC	N/A	IN	N/A	**20%**

PLAN OF CORRECTION

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a statewide, toll-free telephone number 24 hours a day, 7 days per week, with language capability in all languages spoken by beneficiaries of the county that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

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

FINDINGS

The MHP did not furnish evidence its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: the MHP's written log corresponding to the time period of the DHCS test calls. However, it was determined there is insufficient evidence the MHP logs requests made by phone, in person and in writing. The log

did not include any of the DHCS test calls. Protocol question(s) A10b1, A10b2, and A10b3 are deemed OOC.

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

PROTOCOL REQUIREMENTS		
13a.	Regarding the MHP's plan for annual cultural competence training necessary to ensure the provision of culturally competent services:	
	1)	Is there a plan for cultural competency training for the administrative and management staff of the MHP?
	2)	Is there a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP?
	3)	Is there a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing)?
13b.	Does the MHP have evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers?	
• *CCR, title 9, chapter 11, section 1810.410 (a)-(e)* • *DMH Information Notice No. 10-02, Enclosure, Pages 16 & 22 and DMH Information Notice No. 10-17, Enclosure, Pages 13 & 17*	• *MHP Contract, Exhibit A, Attachment I*	

FINDINGS
The MHP did not furnish evidence it has a plan for annual cultural competence training necessary to ensure the provision of culturally competent services. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: the MHP's Cultural Competence Plan for FY15/16 and training materials for trainings offered during the triennial review period. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP did not have a plan for or evidence of implementation of cultural competency training for administrative and management staff and/or persons providing SMHS employed by or contracting with the MHP. The MHP does not have a mechanism to track participation in trainings to ensure all staff and contract providers receive the required training. Protocol question(s) A13a2 and A13b 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 has a plan for annual cultural competence training necessary to ensure the provision of culturally competent services. Specifically, the MHP must develop a plan for, and provide evidence of implementation of, cultural competency training for administrative and management staff as well as persons providing SMHS employed by or contracting with the MHP. The MHP must provide evidence of implementation of training providers (i.e., tracking mechanism to monitor attendance by staff and contract providers).

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SECTION B: AUTHORIZATION

PROTOCOL REQUIREMENTS	
1.	Regarding the Treatment Authorization Requests (TARs) for hospital services:
1a.	Are the TARs being approved or denied by licensed mental health or waivered/registered professionals of the beneficiary's MHP in accordance with title 9 regulations?
1b.	Are all adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by: 1) a physician, or 2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice?
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 authorization policy and procedure: MHP 53 (9/25/15) Contracted Hospital Emergency Admission and Payment. However, while the policy contained all of the required elements, DHCS also inspected a sample of 87 TARs to verify compliance with regulatory requirements. The TAR sample review findings are detailed below:

PROTOCOL REQUIREMENT		# TARS IN COMPLIANCE	# TARs OOC	COMPLIANCE PERCENTAGE
1a	TARs approved or denied by licensed mental health or waivered/registered professionals	87	0	100%
1c	TARs approves or denied within 14 calendar days	75	12	86%

Protocol question(s) B1c 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 complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services.

PROTOCOL REQUIREMENTS	
3.	Regarding payment authorization for Day Treatment Intensive and Day Rehabilitation Services:
3a.	The MHP requires providers to request advance payment authorization for Day Treatment Authorization and Day Rehabilitation in accordance with MHP Contract:
	1) In advance of service delivery when services will be provided for more than 5 days per week.
	2) At least every 3 months for continuation of Day Treatment Intensive.
	3) At least every 6 months for continuation of Day Rehabilitation.
	4) The MHP requires providers to request authorization for mental health services provided concurrently with day treatment intensive and day rehabilitation, excluding services to treat emergency and urgent conditions.

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

FINDINGS

The MHP did not furnish evidence it requires providers to request advance payment authorization for Day Treatment Authorization (DTI) and Day Rehabilitation (DR). DHCS reviewed the MHP's authorization policy and procedure: MHP 19: Authorization Requests for Ongoing Non-Hospital SMHS. In addition, DHCS inspected a sample of 25 authorizations for DTI and DR to verify compliance with regulatory requirements. The DTI/DR authorization sample review findings are detailed below:

PROTOCOL REQUIREMENT		# IN COMPLIANCE	# OOC	COMPLIANCE PERCENTAGE
3a	1) Approved in advance of service delivery when services will be provided for more than 5 days per week	0	5	0%
	2) At least every 3 months for continuation of Day Treatment Intensive	25	0	100%
	3) At least every 6 months for continuation of Day Rehabilitation	25	0	100%
	4) The MHP requires providers to request authorization for mental health services provided concurrently with day treatment intensive and day rehabilitation, excluding services to treat emergency and urgent conditions.	25	0	100%

Five (5) of the 25 DTI/DR authorizations were authorized for more than 5 days of service. However the authorization was not approved in advance of service delivery. Protocol question(s) B3a1 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 requires providers to request advance payment authorization for DTI and DR when services will be provided for more than 5 days per week.

PROTOCOL REQUIREMENTS	
5b.	NOA-B: Is the MHP providing a written NOA-B to the beneficiary when the MHP denies, modifies, or defers (beyond timeframes) a payment authorization request from a provider for SMHS?
• *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)*

FINDING

The MHP did not furnish evidence it provides a written NOA-B to the beneficiary when the MHP denies, modifies, or defers (beyond timeframes) a payment authorization request from a provider for SMHS. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: MHP 22: Notice of Action B and a sample of denied provider

requests for payment authorization. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, in two cases where the MHP denied a provider's request for payment authorization (2015) the MHP did not provide a written NOA-B to the beneficiaries. Protocol question B5b 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-B to the beneficiary when the MHP denies, modifies, or defers (beyond timeframes) a payment authorization request from a provider for SMHS.

PROTOCOL REQUIREMENTS	
5d.	NOA-D: Is the MHP providing a written NOA-D to the beneficiary when the MHP fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals?
• *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)*

FINDING
The MHP did not furnish evidence it provides a written NOA-D to the beneficiary when the MHP fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: QMP 6: Notice of Action D – Delays in Grievance and Appeal Process and the MHP's Grievance and Appeal Log for FY14/15. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, two entries on the grievance and appeal log indicated the MHP did not act within timeframes for the disposition of grievances and there was no evidence a written NOA-D was provided to the beneficiaries. Protocol question(s) B5d 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-D to the beneficiary when the MHP fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

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SECTION C: BENEFICIARY PROTECTION

PROTOCOL REQUIREMENTS	
3.	Regarding established timeframes for grievances, appeals, and expedited appeals:
3a.	1) Does the MHP ensure that grievances are resolved within established timeframes?
	2) Does the MHP ensure that appeals are resolved within established timeframes?
	3) Does the MHP ensure that expedited appeals are resolved within established timeframes?

3b.	Does the MHP ensure required notice(s) of an extension are given to beneficiaries?
	• *CFR, title 42, section 438.408(a),(b)(1)(2)(3)* • *CCR, title 9, chapter 11, section 1850.206(b)* • *CCR, title 9, chapter 11, section 1850.207(c)* • *CCR, title 9, chapter 11, section 1850.208.*

FINDINGS

The MHP did not furnish evidence it ensures grievances, appeals, and expedited appeals are resolved within established timeframes and/or required notice(s) of an extension are given to beneficiaries. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: QMP 2: Problem Resolution of Grievances; FY14/15 Grievance and Appeal Log, and a sample of grievances corresponding with the log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. The MHP received 12 grievances in FY14/15; however, 2 of the 12 grievances were not resolved within established timeframes. The log entries were incomplete and there was no record of a grievance disposition letter in the MHP's records.

The table below details DHCSs findings relative to the sample of grievances reviewed.

		RESOLVED WITHIN TIMEFRAMES		REQUIRED NOTICE OF EXTENSION EVIDENT	COMPLIANCE PERCENTAGE
	# REVIEWED	# IN COMPLIANCE	# OOC		
GRIEVANCES	12	10	0	NO	83%

Protocol question(s) C3a1 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 ensures grievances, appeals, and expedited appeals are resolved within established timeframes.

PROTOCOL REQUIREMENTS	
4.	Regarding notification to beneficiaries:
4a.	1) Does the MHP provide written acknowledgement of each grievance to the beneficiary in writing?
	2) Is the MHP notifying beneficiaries, or their representatives, of the grievance disposition, and is this being documented?
	• *CFR, title 42, section 438.406(a)(2)* • *CCR, title 9, chapter 11, section 1850.205(d)(4)* • *CFR, title 42, section 438.408(d)(1)(2)* • *CCR, title 9, chapter 11, sections 1850.206(b),(c), 1850.207(c),(h), and 1850.208(d),(e)*

FINDINGS

The MHP did not furnish evidence it provides written acknowledgement and notifications of dispositions to beneficiaries for all grievances, appeals, and expedited appeals. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: QMP 2: Problem Resolution of Grievances; FY14/15 Grievance and Appeal Log, and a sample of grievances corresponding with the log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the grievance samples did not have the required written acknowledgement or written grievance disposition for all of the grievances received.

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 provides written acknowledgement and notifications of dispositions to beneficiaries for all grievances, appeals, and expedited appeals.

PROTOCOL REQUIREMENTS	
5.	Does the written notice of the appeal resolution include the following:
5a.	The results of the resolution process and the date it was completed?
5b.	Notification of the right and how to request a State fair hearing, if beneficiary is dissatisfied with the appeal decision?
• *CFR, title 42, section 438.408I(1),(2)(as modified by the waiver renewal request of August, 2002 and CMS letter, August 22, 2003)*	• *DMH Letter No. 05-03* • *CCR, title 9, chapter 11, section 1850.207(h)(3)*

FINDINGS

The MHP did not furnish evidence its written notice of appeal resolution includes the results and completion of the resolutions process and notification of the right to, and how to request, a State fair hearing if the beneficiary is dissatisfied with the appeal decision. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: the MHP's appeal disposition letter template. However, the appeal disposition letter did not include language notifying the beneficiary of the right and how to request a State Fair Hearing if the beneficiary is dissatisfied with the appeal decision. Protocol question(s) C5b 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 its written notice of appeal resolution includes the results and completion of the resolutions process and notification of the right to, and how to request, a State fair hearing if the beneficiary is dissatisfied with the appeal decision.

PROTOCOL REQUIREMENTS	
6.	Is the MHP notifying those providers cited by the beneficiary (or otherwise involved in the grievance, appeal, or expedited appeal) of the final disposition of the beneficiary's grievance, appeal or expedited appeal?
• *CCR, title 9, chapter 11, section 1850.205(d)(6)*	

FINDING

The MHP did not furnish evidence it is notifying those providers cited by the beneficiary (or otherwise involved in the grievance, appeal, or expedited appeal) of the final disposition of the beneficiary's grievance, appeal or expedited appeal. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: QMP 2: Problem Resolution of Grievances and QMP 3: Problem Resolution Appeal Requirements. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the P&P did not specify procedures for notifying providers of the grievance and/or appeal dispositions. Protocol question(s) C6 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 notifies providers cited by a beneficiary (or otherwise involved in the grievance, appeal, or expedited appeal) of the final disposition of the beneficiary's grievance, appeal or expedited appeal.

PROTOCOL REQUIREMENTS	
7.	Does the MHP ensure services are continued while an appeal or State fair hearing is pending?
• *CFR, title 42, section 438.420* • *CCR, title 9, chapter 11, section 1850.215*	• *CCR, title 22, section 51014.2* • *DMH Letter No. 05-03*

FINDING

The MHP did not furnish evidence it ensures services are continued while an appeal or State fair hearing is pending. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: QMP 3: Problem Resolution Appeal Requirements and the Appeal Acknowledgement Letter. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the P&P does not include procedures for ensuring services are continued while an appeal or State fair hearing is pending nor does the MHP's Appeal Acknowledgement Letter include information about Aid Paid Pending. Protocol question(s) C7 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 is ensuring services are continued while an appeal or State fair hearing is pending.

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SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS	
4.	Does the MHP ensure that it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents, as required in CFR, title 42, sections 455.101 and 455.104 and in the MHP Contract, Program Integrity Requirements?
• *CFR, title 42, sections 455.101 and 455.104*	• *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*

FINDING

The MHP did not furnish evidence it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents as required in regulations and the MHP Contract. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: CMP 10: Excluded Individuals and Entities and CMP 14: Disclosure of 5% Interest. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP is not collecting disclosures from contract providers nor is the requirement included in the provider contract language. Protocol question H4 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 collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents as required in regulations and the MHP Contract.

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SECTION G: PROVIDER RELATIONS

PROTOCOL REQUIREMENTS	
3.	Regarding the MHP's network providers, does the MHP ensure the following:
3a.	Mechanisms have been established to ensure that network providers comply with timely access requirements?
3b.	Corrective action is taken if there is a failure to comply with timely access requirements?
• *CFR, title 42, section 438.206(b)(1)* • *CCR, title 9, chapter 11, section 1810.310 (a)(5)(B)*	• *MHP Contract, Exhibit A, Attachment I* • *CMS/DHCS, section 1915(b) waiver*

FINDINGS

The MHP did not furnish evidence it has established mechanisms to ensure that network providers comply with timely access requirements and to take corrective action if providers fail to comply. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: MHP 24: NOA-E, FY14/15 EQRO Report, the Madera Managed Care Manual, and the QI Work Plan (FY14/15). However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP has established timeliness standards; however, it does not have a mechanism for monitoring its network providers to ensure they comply with those requirements. In addition, the MHP was not able to demonstrate corrective action is taken if a network provider fails to comply with timely access requirements. Protocol question(s) G3a and G3b 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 has established mechanisms to ensure that network providers comply with timely access requirements and to take corrective action if providers fail to comply.

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 provided by the MHP for this survey item: MHP 65: Mental Health Services for Individuals with Special Language Needs. 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.

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 provided by the MHP for this survey item: CLN 27: Katie A Services; CLN 26: Katie A Referral Process; and, the Katie A Sub-Class Eligibility Assessment. 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)* • *DMH Letter No. 10-05*	• *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*

SURVEY FINDING
DHCS reviewed the following documentation provided by the MHP for this survey item: CMP 10: Excluded Individuals and Entities. The documentation lacks specific elements to demonstrate compliance with federal and/or State requirements. Specifically, the MHP has not yet begun screening employees and contract providers in the Social Security Administration's Death Master File, the NPPES, or EPLS system (please note: EPLS is now included in the federal SAM database).

SUGGESTED ACTIONS
DHCS recommends the MHP implement the screening of all providers and contractors in all required databases as described above and in regulations.

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 provided by the MHP for this survey item: License Tracking Database. The documentation provides sufficient evidence of compliance with federal and/or State requirements.

SUGGESTED ACTIONS
No further action required at this time.

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 provided by the MHP for this survey item: PHR 40: Medication Monitoring Committee and the MHP's QI Work Plan. The documentation provides sufficient evidence of compliance with federal and/or State requirements.

SUGGESTED ACTIONS
No further action required at this time.

FISCAL YEAR (FY) 2015/2016 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
MADERA COUNTY MENTAL HEALTH PLAN REVIEW
November 16, 2015
FINAL 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 MADERA 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 **121** claims submitted for the months of January, February and March of 2015.

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Medical Necessity 2
Assessment 3
Medication Consent 5
Client Plans 6
Progress Notes 9

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-2:

The medical record associated with the following Line number 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 number 2. 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	
2.	Regarding the Assessment, are the following conditions met:
2a.	1) Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness?
	2) Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency?
• *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*

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) Medications: **Line number 6**
2) Risks: **Line numbers 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10**

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.

PROTOCOL REQUIREMENTS	
2c.	Does the assessment 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 1810.204* • *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 2c:

The Assessment did not include:

1) Signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title:
   - **Line number 6**

PLAN OF CORRECTION 2c:

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

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*

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) Range of frequency: **Line numbers 2 and 9**
2) Dosage: **Line numbers 2 and 9**
3) Method of administration (oral or injection): **Line numbers 2 and 9**
4) Duration of taking each medication: **Line numbers 2 and 9**

5) Possible side effects if taken longer than 3 months: **Line numbers 2 and 9**

6) Consent once given may be withdrawn at any time: **Line number 9**

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		
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-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 2, 6, 7, 8 and 9**

4b-5) One or more of the proposed interventions did not address the mental health needs and functional impairments identified as a result of the mental disorder. **Line numbers 1, 4, 8, 9 and 10**

PLAN OF CORRECTION 4b:

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

1) (4b-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.).
2) (4b-5.) All mental health interventions/modalities proposed on client plans address the mental health needs and identified functional impairments of the beneficiary as a result of the mental disorder.

<table>
<tr><th colspan="2">PROTOCOL REQUIREMENTS</th></tr>
<tr><td>4d.</td><td>Regarding the beneficiary's participation and agreement with the client plan:
1) Is there documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced by, but not limited to:
a. Reference to the beneficiary's participation in and agreement in the body of the client plan; or
b. The beneficiary signature on the client plan; or
c. A description of the beneficiary's participation and agreement in the medical record.</td></tr>
<tr><td></td><td>2) Does the client plan include the beneficiary's signature or the signature of the beneficiary's legal representative when:
a. The beneficiary is expected to be in long-term treatment, as determined by the MHP, and,
b. The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS?</td></tr>
<tr><td></td><td>3) When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, does the client plan include a written explanation of the refusal or unavailability of the signature?</td></tr>
<tr><td>• 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</td><td>• WIC, section 5751.2
• MHP Contract, Exhibit A, Attachment I
• CCR, title 16, Section 1820.5
• California Business and Profession Code, Section 4999.20</td></tr>
</table>

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

RR7. No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.

FINDING 4d-1:

The MHP did not have written documentation standards for the beneficiary's participation in and agreement with the client plan, and for the beneficiary's signature on the client plan.There was no documentation of the beneficiary's or legal representative's degree of participation in and agreement with the plan, and there was no written explanation of the beneficiary's refusal or unavailability to sign the plan, as required in the MHP Contract with the Department:

- **Line numbers 7 and 9**: The beneficiary or legal representative was required to sign the client plan per the MHP Contract with the Department (i.e., long-term treatment and receiving more than one type of SMHS) / per the MHP's written documentation standards. However, the signature was missing. **RR7, refer to Recoupment Summary for details**

Furthermore, the MHP did not have a written definition of what constitutes a "long-term" care beneficiary.

PLAN OF CORRECTION 4d:

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

1) Ensure that the beneficiary's signature is obtained in a timely manner on the client plan as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2)(A)(B).
2) Ensure that services are not claimed when the beneficiary's:
    a) Signature is not obtained when required or not obtained in a timely manner and the reason for refusal is not documented.
3) Establish a written definition of what constitutes a "long-term" care beneficiary in its written documentation standards.

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 9**

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.

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, sections 1840.316 - 1840.322*
• *CCR, title 9, chapter 11, section 1810.440(c)*	• *CCR, title 22, chapter 3, section 51458.1*
• *CCR, title 9, chapter 11, section 1840.112(b)(2-6)*	• *CCR, title 22, chapter 3, section 51470*
• *CCR, title 9, chapter 11, section 1840.314*	• *MHP Contract, Exhibit A, Attachment I*

<u>Reasons for Recoupment (RR)</u>: ***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, 4, 5, 6, 8, 9 and 10: Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period).

  5a-3) Line number 2: The interventions applied, beneficiary's response to the interventions and the location of the interventions.

  5a-4) Line number 4: Timeliness of the progress note could not be determined because the note was signed but not dated by the person providing the service. Therefore, the date the progress note was entered into the medical record could not be determined.

  5a-8) Line number 2: The provider's professional degree, licensure or job title.

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 6 and 7**

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)** Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and the MHP's written documentation standards.
   - **5a-3)** Interventions applied, the beneficiary's response to the interventions and the location of the interventions, as specified in the MHP Contract with the Department.
   - **5a-4)** The date the progress note was completed and entered into the medical record by the person(s) providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.
   - **5a-8)** The provider's/providers' professional degree, licensure or job title.
4) The documentation is individualized for each service provided.

FINDING 5a3:

The progress notes for the following line numbers indicate that the service provided was solely for:

- Clerical: **Line numbers 2 and 10. 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 clerical.
3) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).

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 2 and 3**: The type of specialty mental health service (SMHS) documented on the progress note was not the same type of SMHS claimed. **RR9, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5c:

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

1) Ensure that all SMHS claimed are:

   a) Claimed for the correct service modality and billing code.

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 notes did not include:

- Date of service: **Line number 4**
- Signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title: **Line number 2**
- Date the documentation was entered into the medical record: **Line number 4**

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 that all documentation includes The date the signature was completed and the document was entered into the medical record.

COMPLIANCE RATING BY PERCENTAGE

NAME OF MHP: MADERA

PERIOD REVIEWED: JAN, FEB, MAR 2015

		% In Compliance	% Out of Compliance
OVERALL COMPLIANCE			
Total Number of Claims Reviewed	121		
Total Number of Claims ***ALLOWED***	69	57.0%	
Total Number of Claims ***DISALLOWED***	52		43.0%
MEDICAL NECESSITY			
Total Number of Records Reviewed for Medical Neccessity	121		
Number of Records that ***MET*** medical necessity criteria	114	94.2%	
Number of Records that ***DID NOT MEET*** Medical Necessity	7		5.8%
For diagnosis, Impairment and Interventions proposed			
ASSESSMENT			
10 Assessments reviewed for 10 required elements			
89 of 100 required elements were **present** in the sample		89.0%	
11 of 100 elements were **missing**			11.0%
Reviewed for ALL the Required Elements of an Assessment			
MEDICATION CONSENT			
3 med consents reviewed for 13 required elements			
28 of 39 required elements were **present** in the sample		71.8%	
11 of 39 elements were **missing**			28.2%
Reviewed for ALL of the Required Elementsof a Medication Consent			
CLIENT PLAN			
10 Client Plans reviewed for 10 required elements			
85 of 100 required elements were **present** in the sample		85.0%	
15 of 100 elements were **missing**			15.0%
Reviewed for ALL the Required Elements of a Client Plan			
PROGRESS NOTES			
121 progress notes reviewed for 6 required elements			
686 of 726 required elements were **present** in the sample		94.5%	
40 of 726 elements were **missing**			5.5%
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	2		
Number of medical records that ***MET*** requirements	2	100.0%	
Number of medical records that ***DID NOT MEET*** requirements	0		0.0%
Reviewed for ALL the elements of Cultural Competency and Alternative Format			
DAY TREATMENT INTENSIVE/REHAB			
Number of Claims involving Day Programs			
Number of Day Program Claims that ***MET*** requirements		#DIV/0!	
Number of Day Program Claims that ***DID NOT MEET*** requirements	0		#DIV/0!
Reviewed for ALL Required Elements of Day program i.e components, hours, ratios etc.			

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Total # of Claims 121 # of claims disallowed 52
Percentage Out of Compliance 43%

LINE #	CIN	DOB	CLAIMID	PROV #	DATE OF SERVICE	MODE	SF	UNITS OF TIME	AMOUNT APPROVED	FFP	FMAP	APPROVED AIDCODE	RR #	RECOUPMENT
2	99901778E	19590127	174954645	2055	20150209	18	30	15	$33.45	$33.45	100.00	M1	9	No progress note was found for service claimed. Service claimed does not match service documented on progress note. Case management note claimed as Mental Health Services (SF 30)
2	99901778E	19590127	174954646	2055	20150209	18	30	53	$118.19	$118.19	100.00	M1	4,3	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
2	99901778E	19590127	174954647	2055	20150210	18	30	32	$71.23	$71.23	100.00	M1	4,3	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
2	99901778E	19590127	174954648	2055	20150217	18	30	32	$70.56	$70.56	100.00	M1	4,3	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.

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2	99901778E	19590127	174954649	2055	20150219	18	01	49	$95.65	$95.65	100.00	M1	9,19d	No progress note was found for service claimed. Service claimed does not match service documented on progress note. Case management note claimed as Mental Health Services (SF 30)
2	99901778E	19590127	174954651	2055	20150225	18	60	20	$79.60	$79.60	100.00	M1	17,3,4	The progress note indicates the service provided was solely clerical.
2	99901778E	19590127	176650199	2055	20150304	18	30	13	$28.99	$28.99	100.00	M1	4,3	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
2	99901778E	19590127	176650200	2055	20150310	18	30	29	$64.51	$64.51	100.00	M1	4,3	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
2	99901778E	19590127	176650201	2055	20150317	18	30	32	$70.90	$70.90	100.00	M1	4,3	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.

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2	99901778E	19590127	176650202	2055	20150331	18	30	25	$55.75	$55.75	100.00	M1	4,3	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
3	93659743D	19981119	174955765	2058	20150218	18	30	15	$33.45	$16.73	50.01	60	9	No progress note was found for service claimed. Service claimed does not match service documented on progress note. Case management note claimed as Mental Health Services (SF 30)
3	93659743D	19981119	176651503	2058	20150317	18	30	28	$62.44	$31.22	50.00	60	9	No progress note was found for service claimed. Service claimed does not match service documented on progress note. Case management note claimed as Mental Health Services (SF 30)
5	96074678E	20090128	174956009	2058	20150212	18	01	99	$193.05	$96.52	50.00	30	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.

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5	96074678E	20090128	174956010	2058	20150219	18	1	65	$126.65	$63.32	50.00	30	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
5	96074678E	20090128	176651828	2058	20150312	18	1	109	$212.65	$106.32	50.00	30	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
5	96074678E	20090128	176651829	2058	20150317	18	01	23	$44.75	$22.37	49.99	30	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
5	96074678E	20090128	176651830	2058	20150318	18	01	32	$62.30	$31.15	50.00	30	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.

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6	91819287A	19471203	172582145	2058	20150106	18	30	240	$535.20	$267.60	50.00	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	172582146	2058	20150112	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	172582147	2058	20150121	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	172582148	2058	20150127	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.

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6	91819287A	19471203	174955057	2058	20150202	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	174955058	2058	20150210	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	174955059	2058	20150218	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	174955060	2058	20150224	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.

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6	91819287A	19471203	176650667	2058	20150303	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	176650668	2058	20150310	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	176650669	2058	20150316	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
6	91819287A	19471203	176650670	2058	20150327	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.

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6	91819287A	19471203	176650671	2058	20150330	18	30	240	$535.20	$267.60	50	60	4	Documentation in the medical record does not establish the expectation that the proposed intervention will significantly diminish the impairment or prevent significant deterioration.
7	97919344C	19441104	172581952	2057	20150105	18	1	30	$58.50	$29.25	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
7	97919344C	19441104	176243820	2057	20150105	18	60	30	$30.96	$15.48	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
7	97919344C	19441104	172581953	2057	20150115	18	30	30	$66.90	$33.45	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.

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7	97919344C	19441104	172581954	2057	20150115	18	1	30	$58.50	$29.25	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
7	97919344C	19441104	174954869	2057	20150202	18	30	20	$44.60	$22.30	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
7	97919344C	19441104	174954870	2057	20150210	18	1	42	$81.90	$40.95	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
7	97919344C	19441104	174954871	2057	20150213	18	30	30	$66.90	$33.45	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.

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7	97919344C	19441104	174954872	2057	20150217	18	30	30	$66.90	$33.45	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
7	97919344C	19441104	174954873	2057	20150224	18	30	40	$89.20	$44.60	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
7	97919344C	19441104	176650444	2057	20150324	18	30	30	$66.90	$33.45	50	16	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
9	91307572A	19800630	172581972	2057	20150106	18	30	20	$44.60	$22.30	50	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.

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LINE #	CIN	DOB	CLAIMID	PROV #	DATE OF SERVICE	MODE	SF	UNITS OF TIME	AMOUNT APPROVED	FFP	FMAP	APPROVED AIDCODE	RR #	RECOUPMENT
9	91307572A	19800630	172581973	2057	20150106	18	1	70	$136.60	$68.30	50	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
9	91307572A	19800630	172581974	2057	20150107	18	1	120	$234.00	$117.00	50	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
9	91307572A	19800630	172581975	2057	20150107	18	30	60	$133.80	$66.90	50	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
9	91307572A	19800630	172581976	2058	20150109	18	1	20	$38.90	$19.45	50	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.

State of California
Department of Health Care Services

Mental Health Analytics Section
October 26, 2015

Short-Doyle/Medi-Cal Approved Claims
RECOUPMENT SUMMARY
Confidential Patient Information
See California Welfare and Institutions Code Section 5328 and HIPAA Privacy and Security Rules
JANUARY 2015 THROUGH MARCH 2015

MADERA COUNTY

Total # of Claims 121 # of claims disallowed 52
Percentage Out of Compliance 43%

LINE #	CIN	DOB	CLAIMID	PROV #	DATE OF SERVICE	MODE	SF	UNITS OF TIME	AMOUNT APPROVED	FFP	FMAP	APPROVED AIDCODE	RR #	RECOUPMENT
9	91307572A	19800630	172581977	2057	20150113	18	30	76	$169.48	$84.74	50	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
9	91307572A	19800630	172581978	2057	20150126	18	1	60	$117.00	$58.50	50	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
9	91307572A	19800630	172581979	2057	20150126	18	1	82	$160.00	$80.00	50	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
9	91307572A	19800630	174954874	2058	20150205	18	01	60	$117.00	$58.50	50.00	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.

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MADERA COUNTY

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LINE #	CIN	DOB	CLAIMID	PROV #	DATE OF SERVICE	MODE	SF	UNITS OF TIME	AMOUNT APPROVED	FFP	FMAP	APPROVED AIDCODE	RR #	RECOUPMENT
9	91307572A	19800630	174954875	2057	20150210	18	30	30	$66.90	$33.45	50.00	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
9	91307572A	19800630	174954876	2057	20150210	18	1	30	$58.50	$29.25	50.00	60	7	No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.
10	91206946D	19991124	174955321	2058	20150223	18	30	13	$28.99	$14.49	49.98	30	17,3	The progress note indicates the service provided was solely clerical.
									$10,318.75	$5,503.77				