

STATE DEPARTMENT OF HEALTH CARE SERVICES  
MENTAL HEALTH SERVICES DIVISION  
PROGRAM OVERSIGHT AND COMPLIANCE

ANNUAL REVIEW PROTOCOL FOR CONSOLIDATED  
SPECIALTY MENTAL HEALTH SERVICES  
AND OTHER FUNDED SERVICES

FISCAL YEAR (FY) 2015-2016

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## ENFORCEMENT AND CONSEQUENCES FOR NON-COMPLIANCE/TECHNICAL ASSISTANCE AND TRAINING

In accordance with Welfare and Institutions Code (WIC) Section 5614 this serves to notify the County Mental Health Plan (MHP) pursuant to California Code of Regulations (CCR), Title 9, Chapter 11, Sections 1810.325, 1810.380(b), 1810.385, and WIC Section 14712(e), that if the Department determines that an MHP is out of compliance with State or Federal laws and regulations or the terms of the contract between the MHP and the Department, the Department may take any or all of the following actions:

- (1) Require that the MHP develop a plan of correction. The plan of correction should include the following information:
  - a. Description of corrective actions, including milestones
  - b. Timeline for implementation and/or completion of corrective actions
  - c. Proposed (or actual) evidence of correction that will be submitted to DHCS
- (2) Withhold all or a portion of payments due to the MHP from the Department.
- (3) Impose civil penalties pursuant to Section 1810.385.
- (4) Terminate the contract with the MHP pursuant to Section 1810.323.
- (5) Take other actions deemed necessary to encourage and ensure contract and regulatory compliance.

If the Department determines that an action should be taken pursuant to Subsection (b), the Department shall provide the MHP with a written Notice of Noncompliance. The Notice of Noncompliance shall include:

- (1) A description of the violation
- (2) A description of any corrective action required by the Department and time limits for compliance.
- (3) A description of any and all proposed actions by the Department under this Section or Sections 1810.385 or 1810.323, and any related appeal rights.

The MHP may appeal, in writing:

1. A proposed contract termination to the Department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The Department must grant or deny the appeal within 30 calendar days after receipt of the appeal. In granting an appeal, the Department may take another action available under section 1810.380(b). The Department's election to take another action must not be appealable to the Department. Except for terminations pursuant to section 1810.325(c), the Department must suspend the termination date until the Department has acted on the MHP's appeal.
2. A Notice of Non-Compliance to the Department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The Department must grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. The Department must suspend any proposed action until the Department has acted on the MHP's appeal.

## LIST OF ABBREVIATIONS

24/7	24 HOURS A DAY/SEVEN DAYS A WEEK	MOE	MAINTENANCE OF EFFORT
APP	AID PAID PENDING	MOU	MEMORANDUM OF UNDERSTANDING
CCC	CULTURAL COMPETENCE COMMITTEE	N	NON-COMPLIANCE, FINDING OF
CCPR	CULTURAL COMPETENCE PLAN REQUIREMENTS	NOA	NOTICE OF ACTION
CCR	CALIFORNIA CODE OF REGULATIONS	NPPES	NATIONAL PLAN AND PROVIDER ENUMERATION SYSTEM
CFR	CODE OF FEDERAL REGULATIONS	P	PARTIAL COMPLIANCE
CMS	CENTERS FOR MEDICARE AND MEDICAID SERVICES	P&Ps	POLICIES AND PROCEDURES
CPPP	COMMUNITY PROGRAM PLANNING PROCESS	PCP	PRIMARY CARE PHYSICIAN
DHCS	DEPARTMENT OF HEALTH CARE SERVICES	PHI	PROTECTED HEALTH INFORMATION
DMH	[FORMER] DEPARTMENT OF MENTAL HEALTH (STATE)	PIP	PERFORMANCE IMPROVEMENT PROJECTS
EPSDT	EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT	PLW	PROFESSIONAL LICENSING WAIVER
EPLS	EXCLUDED PARTIES LIST SYSTEM	POA	POINT OF AUTHORIZATION
FY	FISCAL YEAR	PSC	PERSONAL SERVICES COORDINATOR
IMD	INSTITUTION FOR MENTAL DISEASES	QI/QM	QUALITY IMPROVEMENT/ QUALITY MANAGEMENT
IP	IMPLEMENTATION PLAN	QIC	QUALITY IMPROVEMENT COMMITTEE
ITWS	INFORMATION TECHNOLOGY WEB SERVICES	RCL	RATE CLASSIFICATION LEVEL
LEP	LIMITED ENGLISH PROFICIENT	SD/MC	SHORT-DOYLE/MEDI-CAL
LPHA	LICENSED PRACTITIONER OF THE HEALING ARTS	SMHS	SPECIALTY MENTAL HEALTH SERVICES
LPT	LICENSED PSYCHIATRIC TECHNICIAN	SNF	SKILLED NURSING FACILITY
LVN	LICENSED VOCATIONAL NURSE	STP	SPECIALIZED TREATMENT PROGRAM
MC	MEDI-CAL	TAR	TREATMENT AUTHORIZATION REQUEST
MCE	MEDICAL CARE EVALUATION	TBS	THERAPEUTIC BEHAVIORAL SERVICES
MCMCP	MEDI-CAL MANAGED CARE PLAN	TDD/TTY	TELECOMMUNICATION DEVICE FOR THE DEAF/ TEXT TELEPHONE/TELETYPE
MHP	MENTAL HEALTH PLAN	UM/UR	UTILIZATION MANAGEMENT/ UTILIZATION REVIEW
MHRC	MENTAL HEALTH REHABILITATION CENTER	URC	UTILIZATION REVIEW COMMITTEE
MHS	MENTAL HEALTH SERVICES	WIC	WELFARE AND INSTITUTIONS CODE
MHSA	MENTAL HEALTH SERVICES ACT	Y	YES – IN-COMPLIANCE

**SECTION K CHART REVIEW—NON-HOSPITAL SERVICES**

**PLEASE NOTE: CHART REVIEW PROTOCOL ITEMS WILL BE REVIEWED FOR EACH CHART IDENTIFIED IN THE SAMPLE.**

CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
1.	Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c. below)?				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>Review assessment(s), evaluation(s), and/or other documentation to support 1a-1c.</li> <li>Is the beneficiary’s diagnosis included in the list of diagnoses in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R).</li> </ul> <p><b>Compliance Rating:</b> _____% (Number of claims meeting medical necessity criteria/Total number of claims in audit sample)</p>
1a.	1) The beneficiary has a current ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract?				
1b.	<p>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):</p> <ol style="list-style-type: none"> <li>1) A significant impairment in an important area of life functioning.</li> <li>2) A probability of significant deterioration in an important area of life functioning.</li> <li>3) A probability that the child will not progress developmentally as individually appropriate.</li> <li>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.</li> </ol>				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>Refer to CCR, title 9, chapter 11, sections 1830.205 (b)(2)(A-C) and 1830.210.</li> <li>Is there documentation that supports that the beneficiary, as a result of a mental disorder or emotional disturbance listed in CCR, title 9, chapter 1, section 1830.205(b)(1)(A-R) has met at least one (1) of the criteria listed in 1b.</li> </ul>

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CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
1c.	<p>Do the proposed and actual intervention(s) meet the intervention criteria listed below:</p> <p>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).</p>				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Does the proposed intervention(s) focus on the condition(s) identified in No. 1b (1-3) or, for full-scope MC beneficiaries under the age of 21 years, on a condition that SMHS can correct or ameliorate per No.1b (4)?</li> <li>• Is there a connection between the proposed intervention and at least one (1) of the following:               <ul style="list-style-type: none"> <li>A. Diminishing the impairment?</li> <li>B. Preventing a significant deterioration?</li> <li>C. Allowing a child to progress developmentally as individually appropriate?</li> <li>D. Correcting or ameliorating the condition?</li> </ul> </li> </ul>
	<p>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):</p> <p>A. Significantly diminish the impairment.</p> <p>B. Prevent significant deterioration in an important area of life functioning.</p> <p>C. Allow the child to progress developmentally as individually appropriate.</p> <p>D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.</p>				

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		Y	P	N	
1d.	The condition would not be responsive to physical health care based treatment.				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Disorders due to medical conditions are not covered. Examples include, but are not limited to:               <ul style="list-style-type: none"> <li>○ Psychosis due to Wilson’s disease</li> <li>○ Depression due to hypothyroidism</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• CCR, title 9, chapter 11, section 1830.205 (b)(c)</li> <li>• CCR, title 9, chapter 11, section 1830.210</li> <li>• CCR, title 9, chapter 11, section 1810.345(c)</li> <li>• CCR, title 9, chapter 11, section 1840.112(b)(1-4)</li> <li>• CCR, title 9, chapter 11, section 1840.314(d)</li> <li>• CCR, title 22, chapter 3, section 51303(a)</li> <li>• Credentialing Boards for MH Disciplines</li> </ul>					<p><b><u>OUT OF COMPLIANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Criteria 1a-c not supported by documentation.</li> <li>• No connection is identified between the functional impairment as it relates to the diagnosis and the service(s) provided.</li> <li>• No evidence that the intervention(s) provided met the intervention criteria listed in 1c.</li> </ul>
2.	Regarding the Assessment, are the following conditions met:				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Review the MHP’s written documentation standards guidelines.</li> <li>• Review assessment(s), evaluation(s), and/or other documentation to support 2a, 2b, and 2c.</li> <li>• Review the prior and current assessment for timeliness and frequency.</li> <li>• The MHP must establish written standards for timeliness and frequency for the required assessment elements identified in 2c. (Refer to MHP Contract, Exhibit A, Attachment I).</li> </ul>
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?				
					<p><b>Compliance Rating:</b> _____% (Number of assessments meeting requirements/Total number of assessments reviewed in audit sample)</p>

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CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
2b.	Do the Assessments include the areas specified in the MHP Contract with the Department?				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Review for the required appropriate elements. These elements may include, but are not limited to, the following:               <ol style="list-style-type: none"> <li>1) Presenting Problem</li> <li>2) Relevant conditions and psychosocial factors</li> <li>3) Mental Health History</li> <li>4) Medical History</li> <li>5) Medications</li> <li>6) Substance Exposure/Substance Use</li> <li>7) Client Strengths</li> <li>8) Risks</li> <li>9) A mental status examination</li> <li>10) A complete five-axis diagnosis</li> <li>11) Additional clarifying formulation information, as needed</li> </ol> </li> </ul> <p><b>Compliance Rating:</b> _____% (Number of assessments with all required elements/Total number of assessments reviewed in audit sample)</p>
	1) <u>Presenting Problem</u> . The beneficiary’s chief complaint, history of presenting problem(s) including current level of functioning, relevant family history and current family information;				
	2) <u>Relevant conditions and psychosocial factors</u> 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) <u>Mental Health History</u> . 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;				

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CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
4)	<u>Medical History</u> . 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)	<u>Medications</u> . 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)	<u>Substance Exposure/Substance Use</u> . Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs;				
7)	<u>Client Strengths</u> . 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;				

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		Y	P	N	
8)	<u>Risks</u> . Situations that present a risk to the beneficiary and/or others, including past or current trauma;				<b><u>GUIDANCE:</u></b> <ul style="list-style-type: none"> <li>Risk in this context refers to triggers and/or situations (e.g., psychosocial factors) which may present a risk of decompensation and/or escalation of the beneficiary’s condition</li> </ul>
9)	<u>A mental status examination</u> ;				
10)	<u>A Complete Diagnosis</u> ; 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.				
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?				

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CRITERIA	FINDING			INSTRUCTIONS TO REVIEWERS
	Y	P	N	
<ul style="list-style-type: none"> <li>• CCR, title 9, chapter 11, section 1810.204</li> <li>• CCR, title 9, chapter 11, section 1840.112(b)(1-4)</li> <li>• CCR, title 9, chapter 11, section 1840.314(d)(e)</li> <li>• CCR, title 9, chapter 4, section 851- Lanterman-Petris Act</li> <li>• MHP Contract, Exhibit A, Attachment I</li> </ul>	<b><u>OUT OF COMPLIANCE:</u></b> <ul style="list-style-type: none"> <li>• No assessment has been completed.</li> <li>• The assessment or other documents in the medical record do not contain the required elements.</li> <li>• Documentation that is illegible.</li> </ul>			

CRITERIA	FINDING			INSTRUCTIONS TO REVIEWERS
	Y	P	N	
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?				<b><u>GUIDANCE:</u></b> <ul style="list-style-type: none"> <li>• Review the medication orders and medication consents.</li> <li>• Attestation by clinician is not acceptable in lieu of medication consent.</li> <li>• Medication consents should be specific for each medication prescribed.</li> <li>• For circumstances in which a beneficiary does not have a medication history and/or current medications, reviewers should indicate “Not Applicable” in the findings.</li> </ul> <b>Compliance Rating:</b> _____% (Number of med consents meeting requirements/Total number of med consents reviewed in audit sample)
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?				

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CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
	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?				
3c.	Do medication consents 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?				
<ul style="list-style-type: none"> <li>• CCR, title 9, chapter 11, section 1810.204</li> <li>• CCR, title 9, chapter 11, section 1840.112(b)(1-4)</li> <li>• CCR, title 9, chapter 11, section 1840.314(d)(e)</li> <li>• CCR, title 9, chapter 4, section 851- Lanterman-Petris Act</li> <li>• MHP Contract, Exhibit A, Attachment I</li> </ul>		<p><b><u>OUT OF COMPLIANCE:</u></b></p> <ul style="list-style-type: none"> <li>• No assessment has been completed.</li> <li>• The assessment or other documents in the medical record do not contain the required elements.</li> <li>• Medication consent requirements not met.</li> <li>• Documentation that is illegible.</li> </ul>			
4.	Regarding the client plan, are the following conditions met:				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Review the MHP's written documentation standards guidelines.</li> <li>• Review the prior and current client plans for timeliness and frequency.</li> </ul> <p><b>Compliance Rating:</b> _____% (Number of client plans meeting requirements/Total number of client plans reviewed in</p>
4a.	Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?				

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CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
					audit sample)
4b.	<p>Does the client plan include the items specified in the MHP Contract with the Department?</p> <p>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.</p> <p>2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.</p> <p>3) The proposed frequency of intervention(s).</p> <p>4) The proposed duration of intervention(s).</p> <p>5) Interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.</p> <p>6) Interventions are consistent with client plan goal(s)/treatment objective(s).</p> <p>7) Be consistent with the qualifying diagnoses.</p>				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>Review the objectives and interventions of the client plan for compliance as indicated in 4B (1-7).</li> <li>Assessment, Crisis Intervention, Plan Development, and Crisis Stabilization services may be provided prior to completion of the client plan.</li> <li>If MHP does not set its own timeliness standard, initial client plans should be completed within 60 days.</li> <li>The client plan is to be a collaborative process with the beneficiary.</li> <li>A detailed description of the intervention should include a description of specific strategies (i.e., what is being done) within the identified modality and how these strategies address the beneficiary’s functional impairment.</li> </ul>
4c.	<p>Is the client plan signed (or electronic equivalent) by:</p> <p>1) The person providing the service(s) or,</p> <p>2) A person representing a team or program providing the service(s) or,</p> <p>3) A person representing the MHP providing service(s) or,</p> <p>4) By one of the following, as a co-signer, if the</p>				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>MHP must provide a list of (all licensed/waivered/registered) staff, staff signatures (or electronic equivalent), professional degree, and licensure or job title.</li> <li>MHP must provide evidence for registered staff (e.g., print out from Board of Behavioral Science).</li> <li>Consumers/peers must meet MHP’s minimum qualifications.</li> <li>*LPCCs are <b><u>not</u></b> permitted to assess or treat couples or</li> </ul>

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		Y	P	N	
	<p>client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is <u>not</u> of the approved categories, one (1) of the following must sign:</p> <p>A. A Physician            B. A Licensed/Registered/Waivered Psychologist            C. A Licensed/Registered/Waivered Social Worker            D. A Licensed/Registered/Waivered Marriage and Family Therapist            E. A Licensed/Registered/Waivered Professional Clinical Counselor*            F. A Registered Nurse, including but not limited to nurse practitioners, and clinical nurse specialists</p>				<p>families unless the LPCC has completed ALL the required experience and course work on this subject as specified in CA Business and Professions Code Section 4999.20:</p> <ol style="list-style-type: none"> <li>1) <b>Six (6) semester / nine (9) quarter units</b> focused on theory and application of marriage family therapy <b>AND</b></li> <li>2) No less the <b>500 hours</b> of documented <b>supervised experience</b> working directly with couples, families, or children <b>AND</b></li> <li>3) A minimum of six hours of <b>continuing education</b> specific to marriage and family therapy, completed in <b>each license renewal</b> cycle.</li> </ol>
4d.	<p>Regarding the beneficiary’s participation and agreement with the client plan:</p> <ol style="list-style-type: none"> <li>1) Is there documentation of the beneficiary’s degree of participation and agreement with the client plan as evidenced by, but not limited to:               <ol style="list-style-type: none"> <li>a. Reference to the beneficiary’s participation in and agreement in the body of the client plan; or</li> <li>b. The beneficiary signature on the client plan; or</li> <li>c. A description of the beneficiary’s participation and agreement in the medical record.</li> </ol> </li> </ol>				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Review for the beneficiary’s degree of participation and agreement with the plan as follows:            Reference the beneficiary’s participation and agreement in the body of the client plan, the beneficiary’s signature on the client plan, or a description of the beneficiary’s participation and agreement in the medical record.</li> </ul>

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CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
2)	Does the client plan include the beneficiary’s signature or the signature of the beneficiary’s legal representative when: <ul style="list-style-type: none"> <li>a. The beneficiary is expected to be in long-term treatment, as determined by the MHP, and,</li> <li>b. The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS?</li> </ul>				<b><u>GUIDANCE:</u></b> <ul style="list-style-type: none"> <li>• The beneficiary signature is required under the following circumstances:                             <ul style="list-style-type: none"> <li>○ The beneficiary expected to be in long-term treatment as determined by the MHP.</li> <li>○ The beneficiary is receiving more than one type of SMHS.</li> </ul> </li> <li>• The beneficiary is required to sign the client plan per the MHP’s documentation standards guidelines.</li> <li>• Does the MHP have a written definition of what constitutes a long-term care beneficiary?</li> </ul>
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?				<b><u>GUIDANCE:</u></b> <ul style="list-style-type: none"> <li>• When the beneficiary’s signature is required on the client plan and the beneficiary refuses or is unavailable for signature, is there a written explanation of the refusal or unavailability?</li> </ul>
4e.	Is there documentation that the contractor offered a copy of the client plan to the beneficiary?				<b><u>GUIDANCE:</u></b> <ul style="list-style-type: none"> <li>• Review the medical record for documentation.</li> </ul>
4f.	Does the client plan include: <ul style="list-style-type: none"> <li>1) The date of service;</li> <li>2) The signature of the person providing the service (or electronic equivalent); the person’s type of professional degree, and licensure or job title; AND</li> <li>3) The date the documentation was entered in the medical record?</li> </ul>				
<ul style="list-style-type: none"> <li>• CCR, title 9, chapter 11, section 1810.205.2</li> <li>• CCR, title 9, chapter 11, section 1810.254</li> <li>• CCR, title 9, chapter 11, section 1810.440(c)(1)(2)</li> </ul>		<b><u>OUT OF COMPLIANCE:</u></b> <ul style="list-style-type: none"> <li>• Requirements not met in 4a-4c.</li> <li>• Client plan was not completed.</li> </ul>			

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CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
<ul style="list-style-type: none"> <li>• CCR, title 9, chapter 11, section 1840.112(b)(2-5)</li> <li>• CCR, title 9, chapter 11, section 1840.314(d)(e)</li> <li>• DMH Letter 02-01, Enclosure A</li> <li>• WIC, section 5751.2</li> <li>• MHP Contract, Exhibit A, Attachment I</li> <li>• CCR, title 16, Section 1820.5</li> <li>• California Business and Profession Code, Section 4999.20</li> </ul>					<ul style="list-style-type: none"> <li>• Client plan was not updated at least annually and when there were significant changes in the beneficiary's condition.</li> <li>• Client plan was not signed by staff as indicated in 4c.</li> <li>• No evidence that the contractor offered a copy of the client plan to the beneficiary.</li> <li>• No evidence of the beneficiary agreeing or participating in the client plan.</li> <li>• Client plan was not signed by the beneficiary when required.</li> <li>• No written explanation when the beneficiary refuses to sign or is unavailable.</li> <li>• No written definition of what constitutes a long-term care beneficiary.</li> <li>• Documentation that is illegible.</li> </ul>
5a.	<p>Do the progress notes document the following:</p> <ol style="list-style-type: none"> <li>1) Timely documentation of relevant aspects of client care, including documentation of medical necessity?</li> <li>2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions?</li> <li>3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions?</li> <li>4) The date the services were provided?</li> <li>5) Documentation of referrals to community resources and other agencies, when appropriate?</li> <li>6) Documentation of follow-up care or, as appropriate, a discharge summary?</li> </ol>				<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Review the MHP's documentation standards guidelines.</li> <li>• The date the service was documented in the medical record by the person providing the service.</li> </ul> <p><b>Compliance Rating:</b> _____% (Number of progress notes meeting requirements/Total number of progress notes reviewed in audit sample)</p>

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CRITERIA		FINDING			INSTRUCTIONS TO REVIEWERS
		Y	P	N	
	7) The amount of time taken to provide services?				
	8) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?				
5b.	When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include: 1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary?				
	2) The exact number of minutes used by persons providing the service?				<b><u>GUIDANCE:</u></b> <ul style="list-style-type: none"> <li>The time utilized by all those providing services must be added together to yield the total claimable services.</li> </ul>
	3) Signature(s) of person(s) providing the services?				
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><u>GUIDANCE:</u></b> <ul style="list-style-type: none"> <li>The day treatment intensive weekly clinical summary note must be reviewed and signed by one of the following: <ul style="list-style-type: none"> <li>Physician</li> <li>Licensed/Registered/Waivered Psychologist</li> <li>Licensed/Registered/Waivered Social Worker</li> <li>Licensed/Registered/Waivered Marriage and Family Therapist</li> <li>Licensed/Registered/Waivered Professional Clinical Counselor</li> <li>Registered Nurse</li> </ul> </li> <li>Documentation must support the program requirements, the</li> </ul>

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		Y	P	N	
	B. Day rehabilitation C. Adult residential				type of service, date of service and units of time claimed.
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?				
<ul style="list-style-type: none"> <li>• CCR, title 9, chapter 11, section 1810.254</li> <li>• CCR, title 9, chapter 11, section 1810.440(c)</li> <li>• CCR, title 9, chapter 11, section 1840.112(b)(2-6)</li> <li>• CCR, title 9, chapter 11, section 1840.314</li> <li>• CCR, title 9, chapter 11, sections 1840.316 - 1840.322</li> <li>• CCR, title 22, chapter 3, section 51458.1</li> <li>• CCR, title 22, chapter 3, section 51470</li> <li>• MHP Contract, Exhibit A, Attachment I</li> </ul>		<b>OUT OF COMPLIANCE:</b>			<ul style="list-style-type: none"> <li>• Progress notes do not describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan.</li> <li>• Progress notes that do not indicate the date of service, the amount of time, and beneficiary encounters as specified in 5a - 5c.</li> <li>• Documentation that is illegible.</li> <li>• Services not documented timely.</li> <li>• No signature of person providing the services as specified in 5a (8).</li> <li>• Evidence that beneficiaries are not receiving services that were claimed.</li> </ul>
6.	Regarding cultural/linguistic services and availability in alternative formats:				<b>GUIDANCE:</b> <ul style="list-style-type: none"> <li>• Review CCPR, MHP’s policies and procedures and medical records for: <ul style="list-style-type: none"> <li>• If beneficiary is Limited English Proficient (LEP), there is documentation interpreter services were offered and provided and an indication of the beneficiary’s response.</li> </ul> </li> </ul>
6a.	Is there any evidence that mental health interpreter services are offered and provided, when applicable?				

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		Y	P	
		N		
6b.	If the needs for language assistance is identified in the assessment, is there documentation of linking beneficiaries to culture-specific and/or linguistic services as described in the MHP’s CCPR?			<ul style="list-style-type: none"> <li>• There is evidence beneficiaries are made aware that SMHS are available in their preferred language.</li> <li>• Linkages might include referrals to community based organizations or other community resources.</li> <li>• Interpreter services mean oral and sign language.</li> </ul>
6c.	When applicable, is service-related personal correspondence provided in the beneficiary’s preferred language?			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Personal correspondence includes, but is not limited to, client plans, medication consents, Notices of Action, Grievance Disposition letters, etc.</li> </ul>
6d.	When applicable, was treatment specific information provided to beneficiaries in an alternative format (e.g., braille, audio, large print, etc.)?			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• When applicable, review evidence beneficiaries were provided with information in an alternative format.</li> </ul>
<ul style="list-style-type: none"> <li>• CFR, title 42, section 438.10(c)(4),(5)</li> <li>• CCR, title 9, chapter 11, section 1810.405(d)</li> <li>• CCR, title 9, chapter 11, section 1810.410</li> </ul>		<p><b><u>OUT OF COMPLIANCE:</u></b></p> <ul style="list-style-type: none"> <li>• No evidence of 6a-d.</li> </ul>		
7a.	<p><b>Regarding Service Components for Day Treatment Intensive and Day Rehabilitation programs:</b></p> <p>1) Do <i>Day Treatment Intensive</i> and <i>Day Rehabilitation</i> programs include all the following required service components:</p> <p>A. Daily Community Meetings;*</p> <p>B. Process Groups;</p> <p>C. Skill-building Groups; <u>and</u></p>			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Review the MHP’s written documentation standard guidelines.</li> <li>• Review the <u>Written Weekly Schedule</u> for: <ul style="list-style-type: none"> <li>A. Required service components including requirements for community meetings and <i>Day Treatment Intensive</i> psychotherapy.</li> <li>B. Required and qualified staff.</li> <li>C. Documentation of the specific times, location, and assigned staff.</li> </ul> </li> <li>• Community meetings must occur at least once a day and have the following staffing: <ul style="list-style-type: none"> <li>○ For Day Treatment Intensive: Staff whose scope of practice includes psychotherapy.</li> <li>○ For Day Rehabilitation: Staff who is a physician,</li> </ul> </li> </ul>

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		Y	P N	
	D. Adjunctive Therapies?			<p>licensed/waivered/registered psychologist, clinical social worker, marriage and family therapist, or professional clinical counselor, registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist.</p> <ul style="list-style-type: none"> <li>The MHP must retain the authority to set additional higher or more specific standards than those set forth in the MHP Contract, provided the MHP's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary Day Treatment Intensive and Day Rehabilitation.</li> </ul>
	2) Does <i>Day Treatment Intensive</i> include Psychotherapy?			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>Psychotherapy does not include physiological interventions, including medication intervention.</li> <li>Day Rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.</li> </ul>
7b.	<b>Regarding Attendance:</b>			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>Review the progress notes for: <ul style="list-style-type: none"> <li>A. Documentation of attendance in the total number of minutes/hours.</li> <li>B. <i>Day Treatment Intensive</i> and <i>Day Rehabilitation</i> services were provided as claimed.</li> <li>C. If the beneficiary is unavoidably absent and does not attend the scheduled hours of operation, there is a separate entry in the medical record documenting the reason and the total minutes/hours of actual attendance.</li> </ul> </li> <li>Per the MHP Contract, Exhibit A, Attachment I, in cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the beneficiary's need for the <i>Day Rehabilitation</i> or <i>Day Treatment Intensive</i> program and takes appropriate action.</li> </ul>
	<p>1) Is there documentation of the total number of minutes/hours the beneficiary actually attended the program?</p> <p>2) If the beneficiary is unavoidably absent:</p> <p>A. Is the total time (number of hours and minutes) the beneficiary actually attended the program that day documented;</p> <p>B. Is the beneficiary present for at least 50 percent of the scheduled hours of operation for that day; <b><u>AND</u></b>,</p> <p>C. Is there a separate entry in the medical record documenting the reason for the unavoidable absence?</p>			

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7c.	<p><b>Regarding Continuous Hours of Operation:</b></p> <p>Did the provider apply the following when claiming for the continuous hours of operation of <i>Day Treatment Intensive</i> and <i>Day Rehabilitation</i> services?</p> <p>A. For <u>Half Day</u>: The beneficiary received face-to-face services a <u>minimum</u> of three (3) hours each day the program was open.</p> <p>B. For <u>Full-Day</u>: The beneficiary received face-to-face services in a program with services available <u>more than</u> four (4) hours per day.</p>			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>Review <u>Written Weekly Schedule</u> and other documentation to ensure this requirement is met.</li> <li>Breaks between activities, as well as lunch and dinner breaks, do not count toward the total continuous hours of operation for purposes of determining minimum hours of service.</li> </ul>
7d.	<p><b>Regarding Staffing Requirements:</b></p> <p>1) Do <i>Day Treatment Intensive</i> and <i>Day Rehabilitation</i> meet the following staffing requirements:</p> <p>A. For <i>Day Treatment Intensive</i>: Psychotherapy is provided by licensed, registered, or waived staff practicing within their scope of practice.</p> <p>B. For all scheduled hours of operation: There is at least one staff person present and available to the group in the therapeutic milieu.</p>			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>Review the <u>Written Weekly Schedule</u>, progress notes and other documentation to determine if the required and qualified staff were available for all scheduled hours of operation.</li> </ul>

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		Y	P	N
7e.	<p><b>Regarding Documentation Standards:</b></p> <p>1) Is the required documentation timeliness/frequency for <i>Day Treatment Intensive</i> or <i>Day Rehabilitation</i> being met?</p> <p>A. For <i>Day Treatment Intensive</i> services:</p> <ul style="list-style-type: none"> <li>• Daily progress notes on activities; <u>and</u></li> <li>• A weekly clinical summary.</li> </ul> <p>B. For <i>Day Rehabilitation</i> services:</p> <ul style="list-style-type: none"> <li>• Weekly progress note.</li> </ul>			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Review for: <ul style="list-style-type: none"> <li>A. Required documentation timeliness/frequency for <i>Day Treatment Intensive</i> and <i>Day Rehabilitation</i>.</li> <li>B. Required and qualified staff documenting and providing the service.</li> <li>C. Required standards for all entries in the medical record.</li> </ul> </li> <li>• The <i>Day Treatment Intensive</i> weekly clinical summary must be reviewed and signed by a physician, a licensed/ waived/registered psychologist, clinical social worker, marriage and family therapist, or professional clinical counselor; or a registered nurse who is either staff to the <i>Day Treatment Intensive</i> program or the person directing the service.</li> </ul>
	<p>2) Do all entries in the beneficiary’s medical record include:</p> <p>A. The date(s) of service;</p> <p>B. The signature of the person providing the service (or electronic equivalent);</p> <p>C. The person’s type of professional degree, licensure or job title;</p> <p>D. The date of signature;</p> <p>E. The date the documentation was entered in the beneficiary record; <u>and</u></p> <p>F. The total number of minutes/hours the beneficiary actually attended the program?</p>			
7f.	<p><b>Regarding the Written Program Description:</b></p> <p>1) Is there a <u>Written Program Description</u> for <i>Day Treatment Intensive</i> and <i>Day Rehabilitation</i>?</p> <p>A. Does the <u>Written Program Description</u> describe the specific activities of each</p>			<p><b><u>GUIDANCE:</u></b></p> <ul style="list-style-type: none"> <li>• Review the <u>Written Program Description</u> and <u>Written Weekly Schedule</u> to determine if: <ul style="list-style-type: none"> <li>A. There are specific activities described for each service component.</li> </ul> </li> </ul>

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		Y	P	N
	service and reflect each of the required components of the services as described in the MHP Contract.			B. All required service components are reflected in the <u>Written Program Description</u> , as well as indicated on the <u>Written Weekly Schedule</u> .
2)	Is there a <u>Mental Health Crisis Protocol</u> ?			C. Required and qualified staff were available for all scheduled hours of operation.
3)	Is there a <u>Written Weekly Schedule</u> ?  A. Does the <u>Written Weekly Schedule</u> : a) Identify when and where the service components will be provided and by whom; <u>and</u> b) Specify the program staff, their qualifications, and the scope of their services?			<ul style="list-style-type: none"> <li>If the MHP uses <i>Day Treatment Intensive</i> and/or <i>Day Rehabilitation</i> staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), there must be documentation of the scope of responsibilities for these staff and the specific times in which <i>Day Treatment Intensive</i> or <i>Day Rehabilitation</i> activities are being performed exclusive of other activities.</li> </ul>
<ul style="list-style-type: none"> <li>CCR, title 9, chapter 11, section 1810.212</li> <li>CCR, title 9, chapter 11, section 1810.213</li> <li>CCR, title 9, chapter 11, section 1840.112(b)</li> <li>CCR, title 9, chapter 11, section 1840.314(d)(e)</li> <li>CCR, title 9, chapter 11, section 1840.318</li> <li>CCR, title 9, chapter 11, section 1840.360</li> <li>MHP Contract, Exhibit A, Attachment I</li> <li>DMH Letter No. 03-03</li> </ul>		<b><u>OUT OF COMPLIANCE:</u></b> <ul style="list-style-type: none"> <li>The service components for <i>Day Treatment Intensive</i> and <i>Day Rehabilitation</i> were not offered or provided; or were provided by staff outside their scope of practice.</li> <li>Staff not present as required in 7d.</li> <li>Beneficiary attendance requirements were not met.</li> <li>No documentation of the total number of minutes/hours the beneficiary actually attended the program.</li> <li>When unavoidably absent, no documentation of the reason and/or total number of minutes/hours of actual attendance.</li> <li>Scheduled hours of continuous operation requirements for <i>Day Treatment Intensive</i> and <i>Day Rehabilitation</i> were not met.</li> <li>No documentation of the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, and/or date of signature.</li> <li>Daily progress notes and weekly clinical summary requirements were not met.</li> <li><u>Written Weekly Schedule</u> or <u>Written Program Description</u> requirements were not met.</li> </ul>		