


Contra Costa County Health Services Department Behavioral Health Services Division Mental Health Services	POLICY NO. 713-MH Effective as of: July 1, 2022 Next Review Date: July 31, 2025 Policy Expires On: July 31, 2026
POLICY: <u>UTILIZATION REVIEW: MENTAL HEALTH DOCUMENTATION STANDARD COMPLIANCE AND COMPLIANCE AND QUALITY MONITORING (LEVEL II AND CENTRALIZED REVIEW)</u>	By:  Suzanne Tavano, PhD Behavioral Health Director

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I. PURPOSE:

The purpose of this policy is to establish and outline the corrective action that should take place when documentation of Contra Costa Behavioral Health Services Division (BHSD) County Owned and Operated clinic and Community Based Organization (CBO) providers do not meet BHSD standards and requirements as outlined in Policy 709-MH, Quality Management/Utilization Review: Mental Health Documentation Standards.

II. REFERENCES:

- CFR, Title 22
- CCR, Title 9, Chapter 11
- California Department of Health Care Services (DHCS), Behavioral Health Information Notice (BHIN) No. 22-011
- DHCS, Behavioral Health Information Notice (BHIN) No. 22-013
- DHCS, Behavioral Health Information Notice (BHIN) No. 22-016
- DHCS, Behavioral Health Information Notice (BHIN) No. 22-019
- Contra Costa Mental Health Plan for Consolidated Specialty Medi-Cal Mental Health Services
- Policy 509-MH, Criteria for Beneficiary Access to Specialty Mental Health Services, Medical Necessity and Other Coverage Requirements (CalAIM Initiative)
- Policy 709-MH, Utilization Management/Utilization Review: Mental Health Documentation Standards
- Policy 831-MH, Scope of Practice and Clinical Supervision Guidelines

III. POLICY:

It is the policy of BHSD that when service documentation does not meet BHSD standards and requirements, evaluation for possible corrective action will be initiated.

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IV. AUTHORITY/RESPONSIBILITY:

Mental Health Program Chiefs
 Mental Health Program Managers/Supervisors
 Utilization Review Manager
 Utilization Review Coordinators
 Utilization Review Mental Health Clinical Specialists
 Mental Health Service Providers

V. PROCEDURE:

- A. All services provided by BHSD County Owned and Operated clinic and Community Based Organization (CBO) providers shall be held to documentation standards as described in Policy 709-MH, Utilization Management/Utilization Review: Mental Health Documentation Standards.
- B. Definition/Responsibilities.
1. Service providers.
 - a. For the purpose of this policy, service providers are defined as staff who provide specialty mental health services to BHSD clients and are comprised of the following staff categories with the associated degrees or credentials listed:
 - i) Licensed Mental Health Professionals (with credentials LCSW, MFT, PhD, or PsyD)
 - ii) Licensed Eligible Mental Health Professionals (with credentials AMFT, ASW, Waivered Psychologists, Doctoral Interns, Trainees)
 - iii) Licensed Psychiatric Health Professionals (with credentials MD, NP, RN, LPT)
 - iv) Designated Staff: Unlicensed service providers who provide direct clinical services to clients and who document the services they provide in the mental health record (MHRS or DMHW).

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- b. Service providers shall ensure that all documentation is based on the clinical standards and documentation requirements included in the most recent Clinical Documentation Manual and other distributed memos, training materials, bulletins and DHCS Information Notices (see Policy 709-MH).
 - c. Service providers shall attend documentation training within six (6) months of start of employment and continue training as directed.
 - 2. Clinical supervisors.
 - a. For purposes of this policy, clinical supervisors are defined as the program managers and program supervisors who are responsible for the performance of service providers as defined above. The clinical supervisor is responsible for ongoing supervision, regular evaluations, staff meetings, and individual training to ensure that service providers are appropriately documenting services.
 - b. Clinical supervisors shall ensure that service providers are aware of all requirements for appropriate and accurate billing and that service providers are trained in this regard.
- C. CCBHS-MHP shall review a 10% sample of open Medi-Cal cases for each agency during each fiscal year (July 1-June 30).
- D. Level II/Centralized Review Committee:
 - 1. Level II Reviews and Centralized Committee Meetings are both held at least one (1) time per month.
 - 2. The Level II Review and Centralized Committees are generally comprised of the following members:
 - a. Program Managers/Supervisors.
 - b. UR Coordinators.
 - c. UR Mental Health Clinical Specialists.
 - d. Clinic Mental Health Clinical Specialists/Team Leads.
 - e. UR Clerk.
 - 3. Level II/Centralized Committee responsibility:

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- a. The Program Manager/Supervisor, UR Coordinator, UR Mental Health Clinical Specialist and Mental Health Clinical Specialists/Team Leads are responsible for conducting chart reviews.
- b. The UR Coordinator or the UR Manager’s designee is responsible for generating the Committee Finding Report.
- c. The UR Clerk coordinates the Compliance and Quality Monitoring Committee Meetings and is responsible for collecting and organizing documentation to be reviewed.

E. Review Sample:

The review sample is generated using the SCR 4668 report (MH Admission by Fac/Prog or PSP) using the following parameters:

1. Service provided in Identified Fac/Prog.
2. Services rendered during Identified Review Period.
3. If applicable, services rendered by Identified Staff.
4. If applicable, Identified Service Modes.

F. Level II Review/Centralized Activity:

1. County owned and operated clinics and CBOs who provide mental health services undergo post-service chart review. Upon request of the UR Coordinator, CCBHS-MHP County Owned and Operated clinics and CBOs must provide their medical records for review/review.
2. A review tool will be utilized during Level II Review/Centralized to ensure the following:
 - a. All medical and service necessity criteria are met as established in Policy 709-MH.
 - i) A current ICD-10 diagnosis is listed as the primary diagnosis.
 - ii) A Problem List and Treatment Plan (for Targeted Case Management and Case Management) has been created and is current.

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- b. Clients are receiving services at the appropriate level of care.
 - c. Documentation meets the CCBHS-MHP standards as established in Policy 709-MH.
 - d. All services have been provided within Scope of Practice guidelines as established in Policy 831-MH.
 - e. Required documentation is adequately completed, and all required elements are present.
 - f. Signatures are present on all assessments and progress notes.
 - g. Documentation is located for each service claimed.
3. All Specialty Mental Health programs shall be reviewed in accordance with the required State regulatory compliance standards.
4. A formal written summary shall be submitted to the CBO Agency within thirty (30) business days of the review.
- a. The formal written findings will outline all fraud, waste, and abuse and will identify items of recoupment.
 - i) Should the Provider wish to appeal any of the disallowances, they must submit an appeal in writing within fifteen (15) business days upon receipt of the formal written summary. Appeals shall be sent to the Quality Improvement Coordinator for review and decision.
 - b. Quality issues will not be subject to recoupment but will require a Corrective Action Plan.
 - c. Providers are required to submit a written Corrective Action Plan within thirty (30) business days of receipt of formal written findings for fraud, waste, and abuse issues as well as quality issues, and it must address all issues identified.
 - d. Providers must submit Form MHA-066, Mental Health Service Void and Replace Request, for services that were identified as subject to recoupment.
5. Should the Centralized Committee find that the outcome of the compliance review requires a higher administrative decision, the UR

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Department Manager or their designee will refer the case to the appropriate Mental Health Program Chief.

G. Corrective Action for non-compliance.

1. In order to ensure compliance with BHSD policy and procedures, clinical supervisors shall take corrective action if service providers are not compliant with established documentation requirements. This may include training, counseling, and formal disciplinary action.
2. It is the responsibility of clinical supervisors to ensure that service providers receive documentation training and to monitor documentation on an ongoing basis to ensure compliance.
3. Clinical supervisors shall meet with service providers and review the audit findings and expectations concerning documentation.
4. A clinical supervisor may make a referral to the Utilization Review Manager or designee and the appropriate Program Chief to conduct up to a 100% audit of a service provider's caseload. Closed cases may also be reviewed.