



MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES
REASONS FOR RECOUPMENT
FISCAL YEAR 2021/2022

NON-HOSPITAL SERVICES

Medical Necessity / Beneficiary Criteria / Need for Specialty Mental Health Services / Assessment

1. Mental Health Plan (MHP) did not submit documentation that Medical Necessity Criteria was met and that substantiated the beneficiary's need for Specialty Mental Health Services (SMHS).

MHP Contract, Exhibit A, Attachment 3; Title 9 of the California Code of Regulations § 1830.205(b)(1) and 1830.210; and, MHSUDS Information Notice or Behavioral Health Information Notice (BHIN).

Clinical Documentation

2. The MHP claimed for a service where the MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary
 - a) There was no Progress Note or other clinical documentation to substantiate the service was provided.
 - b) The Progress Note or other clinical documentation indicated "No show" or "Appointment cancelled" but a service (other than chart review) was still claimed.
 - c) The documented service provided did not meet the applicable definition of a SMHS.

CCR, title 9, section 1840.112(b)(3); [MHSUDS Information Notice 17-040](#); MHP Contract, Exhibit E, Attachment 1); CCR, title 22, section 51458.1(a)(3)(7).

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

CCR, title 9, section 1840.314(d); [MHSUDS Information Notice 17-040](#).

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

MHP Contract; MHSUDS Information Notice 17-040.

5. The service claimed did not match the service documented in the progress note. ("Recovery" is limited to mismatches resulting in "overbillings").

CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).

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6. The date of service documented in the progress note does not match the date of service claimed. (*“Recovery” is limited to examples where the MHP is unable to provide other documented evidence that the progress note with the “mismatched” date actually corresponds to the claim in question, and/or was due to a clerical error.*)

CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).

7. The units of time claimed for the service are higher than the amount of time of the service documented in the progress note. (*“Recovery” is limited to mismatches resulting in “overbillings”.*)

CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c); MHP Contract; CCR, title 9, section 1840.112(b)(3); CCR, title 22, section 51458.1(a)(3).

8. For service activities involving one (1) or more providers, progress notes, or other relevant documentation in the medical record, did not clearly include the following:
- a) The total number of providers and their specific involvement in the context of the mental health needs of the beneficiary;
 - b) *The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable;*
 - c) *The total number of beneficiaries participating in the service activity.*

CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5; [MHSUDS Information Notice 17-040](#); CCR, title 22, section 51458.1(a)(3).

9. The claim for a group activity, which is provided as a Mental Health Service, Medication Support, Crisis Intervention, or TCM service, was not properly apportioned to all clients present, and resulted in excess time claimed. (*“Recovery” is limited to apportionments resulting in “overbillings”.*)

CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; [MHSUDS Information Notice 17-040](#); CCR, title 22, section 51458.1(a)(3).

10. The service provided was a Non-Reimbursable Service and 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
 - d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.
 - e) Transportation
 - f) Clerical
 - g) Payee Related

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*CCR, title 9, sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), 1840.312(a-f)
CCR, title 22, section 51458.1(a)(7).*

11. The beneficiary received the service at a location that was ineligible for Federal Financial Participation (e.g., Institution for Mental Disease [IMD], jail, and other similar settings, or in setting subject to lockouts per CCR, Title 9, Chapter 11).

NOTE: When a beneficiary who resides in a setting in which s/he would normally be ineligible for Medi-Cal is moved off grounds to an acute psychiatric inpatient hospital or PHF, that individual again becomes Medi-Cal eligible (unless the hospital is free-standing with more than 16 beds and is thus considered an IMD and the beneficiary is between the ages of 21-64).

CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, part 435, sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d.

12. The service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (A dependent minor in a juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary, is Medi-Cal eligible. See CCR, title 22, section 50273(c)(5). A delinquent minor is only Medi-Cal eligible after adjudication for release into community. See CCR, title 22, section 50273(c)(1)).

Code of Federal Regulations, title 42, sections 435.1009 – 435.1010; CCR, title 22, section 50273(a)(5-8), (c)(1, 5); title 22, section 51458.1(a)(8).

Day Treatment Intensive / Day Rehabilitation (DTI/DR)

13. On a day where the beneficiary was present for at least 50% of the scheduled DTI/DR program time, but was not in attendance for the full hours of operation for that day, there is no documentation of the reason for an "unavoidable absence" which clearly explains why the beneficiary could not be present for the full program on the day claimed.

CCR, title 9, 1840.318; [DMH Information Notice 03-03](#); MHP Contract; [MHSUDS Information Notice 17-040](#).

14. The actual number of hours and minutes the beneficiary attended the DTI/DR program (e.g., 3 hours and 58 minutes) is not documented and for this reason it cannot be established that the beneficiary was present for at least 50% of the program time for the day reviewed.

[DMH Information Notice 03-03](#); MHP Contract; [MHSUDS Information Notice 17-040](#).

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15. Documentation reviewed, including the written weekly schedule for DTI/DR along with the progress notes, reflects that the program does not meet the time requirements for a half-day or full-day program as follows:
- a) Half day program was less than 3 hours (requirement is for 4 hours or less, **but a minimum of 3 hours**)
 - b) Full day program was 4 hours or less (requirements is for **more than 4 hours**)

CCR, title 9, 1840.318; [DMH Information Notice 03-03](#); MHP Contract; [MHSUDS Information Notice 17-040](#).

16. Required DTI/DR documentation was not present as follows:
- a) There was not a clinical summary present for Day Treatment Intensive Services for the week of the service reviewed.
 - b) There was not a daily progress note present for Day Treatment Intensive Services for the day of the service reviewed.
 - c) There was not a weekly progress note present for Day Rehabilitation Services for the week of the service reviewed.

CCR, title 9, 1840.318; [DMH Information Notice 03-03](#); MHP Contract; [MHSUDS Information Notice 17-040](#).

SHORT-DOYLE MEDI-CAL HOSPITAL SERVICES

Medical Necessity

17. Admission (Note: If the concurrent review was conducted by the MHP, documentation of MHP review of the record in a manner consistent with the MHPs policies, [BHIN 19-026](#), and approval of an inpatient stay is sufficient to meet the criteria below.)
- a) Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R), or in the current BHIN annual ICD-10 diagnosis code update.
 - b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.
 - c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), or in the current BHIN annual ICD-10 diagnosis code update the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:
 - i. Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction.
 - ii. Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
 - iii. Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health.

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- iv. Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function.
- v. Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized.

CCR, title 9, section 1820.205(a); See Also title 9, sections 1820.220, 1820.225 and 1820.230.

18. Continued Stay Services (Note: If the concurrent review was conducted by the MHP, the clinician certification and MHP Utilization Management (UM) approval are sufficient to meet these criteria.)
- a) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion
 - b) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), or in the current BHIN annual ICD-10 diagnosis code update, the beneficiary requires continued stay services in an acute psychiatric inpatient hospital for one of the following reasons:
 - i. Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction.
 - ii. Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter.
 - iii. Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health.
 - iv. Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function.
 - v. Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized.
 - vi. Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
 - vii. Presence of new indications that meet medical necessity criteria specified in 17. above.
 - viii. Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital.

CCR, title 9, section 1820.205 See Also title 9, sections 1820.220, 1820.225 and 1820.230.

Administrative Day Requirements

19. Documentation in the medical record does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

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CCR, title 9, section 1820.205(b), See also sections 1820.220(a)(5), (l)(5)(A), 1820.230(a)(2), (d)(1), (2)(A).

20. Documentation provided by the MHP does not establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital does not document contacts with a minimum of five (5) appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements:
- a) The MHP or its designee may waive the requirement of five (5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one (1) contact per week.
 - b) The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:
 - i. The status of the placement option.
 - ii. The date of the contact.
 - iii. Signature of the person making the contact.

CCR, title 9, sections 1820.220(a)(5), (l)(5)(B), 1820.230(d)(2)(B).

Client Plan

21. The attending physician or staff physician did not establish a written plan of care for each applicant or beneficiary before admission to a mental hospital or before authorization for payment, which must be done either by the MHPs Point of Authorization prior to admission of the beneficiary or by the hospital Utilization Review Committee or its designee, "no later than the third working day from the day of [the beneficiary's] admission."

NOTE: The physician's signature and date on the written plan of care indicates the physician's establishment of the plan and that the relevant time frame has been met.

Code of Federal Regulations, title 42, sections 456.80, 456.180 and 456.481; CCR, title 9, sections 1820.210, 1820.220(a)(1) and 1820.230(a)(1), (2) and (b).

Other

22. A hospital day was claimed and paid (1) on which the beneficiary was not a patient in the hospital or (2) for the day of discharge, neither of which is reimbursable.

CCR, title 9, section 1840.320(b)(1), (3); Title 22, section 51470(a).