ADULT MENTAL HEALTH SERVICES Clinical/Quality Review

v.4-15-15

Complete the following:

1. **Date:**
2. **Client Name:**
3. **Client Insyst #:**
4. **Provider Name:**
5. **Reporting Unit:**_____
6. **Clinician:**
7. **Episode Opening Date:**
8. **Authorization Cycle:**

Request for (check all that apply):

9. Mental Health Services:

☐ **Individual Psychotherapy**	**Frequency**	_____	and As Needed ☐	**Duration**	_____
☐ **Individual Rehabilitation**	**Frequency**	_____	and As Needed ☐	**Duration**	_____
☐ **Medication Services**	**Frequency**	_____	and As Needed ☐	**Duration**	_____
☐ **Case Management/Brokerage**	**Frequency**	_____	and As Needed ☐	**Duration**	_____
☐ **Family Psychotherapy**	**Frequency**	_____	and As Needed ☐	**Duration**	_____
Group Services					
☐ **Family Collateral Group**	**Frequency**	_____	and As Needed ☐	**Duration**	_____
☐ **Multi-Family Therapy**	**Frequency**	_____	and As Needed ☐	**Duration**	_____
☐ **Psychotherapy Group**	**Frequency**	_____	and As Needed ☐	**Duration**	_____
☐ **Rehabilitation Group**	**Frequency**	_____	and As Needed ☐	**Duration**	_____

10. Day Treatment Services (check all that apply):

Intensive: ☐ **5 Days/Week or Less** ☐ **Exceeds 5 Days/Week** ☐ **Initial** ☐ **90 Days (3 months)**

Rehabilitative ☐ **5 Days/Week or Less** ☐ **Exceeds 5 Days/Week** ☐ **Initial** ☐**180 Days (6 months)** ☐ **Other**

11. Discharge Readiness Criteria & Tentative Date:

12. Medical Necessity- (Medi-Cal Included Diagnosis; Support for Primary Diagnosis, Impairments to Functioning):

13. Focus of Treatment (Address Barriers to Lower Level of Care, Psychological issues, Risk (s) to Client or Others, Co-Occurring Issues etc.):

14. List Proposed Interventions (i.e. CBT, M.I., If a Risk has been identified include how these will be assessed and contained.):

15. Agency Clinician: _____ **Recommended Approval:** ◯**Yes** ◯**No**

Signature/Credentials

16. Agency Supervisor: _____ **Recommended Approval:** ◯**Yes** ◯**No**

Signature/Credentials

17. CQRT Reviewer: _____ **Recommended Approval:** ◯**Yes** ◯**No (30 Day Return)**

Signature/Credentials

18. ☐**Full Authorization - Start Date:** **End Date:**_____

19. 30 Day Returns:

☐**30 Day Authorization - Chart to be returned to CQRT:**

☐**No Authorization - Chart to be returned to CQRT:**

20. CQRT Chair Comments:

21. Chart to be returned to CQRT - Date:_____

22. CQRT Chair Signature/Credentials:_____**Date:**_____

Regulatory Compliance revised 04.15.2015

Provider Name & RU:

Medical Necessity	Yes	No	N/A
1. Primary diagnosis from CA- DHCS Medi-Cal Included Diagnosis List	☐	☐	☐
2. Documentation supports primary diagnosis (es) for treatment.	☐	☐	☐
3. Impairment Criteria: *Must have one of the following as a result of dx*			
3A. Significant impairment in important area of life functioning, or	☐	☐	☐
3B. Probable significant deterioration in an important area of life functioning, or	☐	☐	☐
3C. Probable the child won't progress developmentally, as appropriate, or	☐	☐	☐
3D. If EPSDT: MH condition can be corrected or ameliorated	☐	☐	☐

4. Intervention Criteria: Must have: 4A and 4B, or 4C, or 4D			
4A. Focus of proposed intervention: Address condition above, and	☐	☐	☐
4B. Proposed intervention will diminish impairment/prevent significant deterioration in important area of life functioning, and/or	☐	☐	☐
4C. Allow child to progress developmentally as appropriate, or	☐	☐	☐
4D. If EPSDT, condition can be corrected or ameliorated	☐	☐	☐

Service Necessity: Must have both 5 and 6			
5. The mental health condition could not be treated by a lower level of care? (true = yes)	☐	☐	☐
6. The mental health condition would not be responsive to physical health care treatment? (true=yes)	☐	☐	☐

Informing Materials:			
7. Informing Materials signature page completed & is signed on time	☐	☐	☐
8. Releases of information, when applicable	☐	☐	☐
9. Informed Consent for Medication(s), when applicable	☐	☐	☐

Special Needs:			
10. Client's cultural/comm. needs noted or lack thereof	☐	☐	☐
11. Client's cultural/communication needs addressed if identified	☐	☐	☐
12. Client's physical limitations are noted or lack thereof	☐	☐	☐
13. Client's physical limitations are addressed if identified	☐	☐	☐

Chart Maintenance			
14. Writing is legible	☐	☐	☐
15. Signatures are legible			
16. Admission date is noted correctly	☐	☐	☐
17. Filing is done appropriately.	☐	☐	☐
18. Client identification is present on each page in the clinical record.	☐	☐	☐
19. Discharge/termination date noted, when applicable.	☐	☐	☐
20. Emergency info. is in a designated location in file/EHR	☐	☐	☐

Med Order Sheet/Progress Note			
21. Med Log updated at each visit, and with: (i.e. 4/8/10; Seroquel; 200mg; 1 po QHS; Marvin Gardens, MD)	☐	☐	☐
22. Date	☐	☐	☐
23. Drug name	☐	☐	☐
24 .Drug Strength/Size	☐	☐	☐
25. Instructions/ Frequency	☐	☐	☐
26. Signatures/Initials	☐	☐	☐

Assessment:			
27. Initial Assessment done by 30 days of episode opening date.	☐	☐	☐
28. Annual Assessment completed on time	☐	☐	☐
29. Dx is established by licensed LPHA or co-signed by licensed LPHA for waivered & registered staff.	☐	☐	☐
30. Psychosocial history.	☐	☐	☐
31. Presenting problems & relevant conditions.	☐	☐	☐
32. Risk(s) to client and/or others assessed.	☐	☐	☐
33. Client strengths/supports.	☐	☐	☐
34. Hx of Psychiatric Medications prescribed.	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 35.Noted in chart	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 36. Noted prominently on chart's cover or in EHR	☐	☐	☐
37. Relevant medical conditions/hx noted & updated.	☐	☐	☐
38. Mental health history.	☐	☐	☐
39. Relevant mental status exam (MSE).	☐	☐	☐
40.Past & Present Substance Exposure/Substance Use: Tobacco, Alcohol, Caffeine, CAM, Rx, OTC drugs, & illicit drugs.	☐	☐	☐
41. Youth: Pre/perinatal events & complete dev. hx.	☐	☐	☐
42.Annual Community Functioning Evaluation (ACFE) N/A for FSP/Brief Service Programs & Level 3)	☐	☐	☐

Client Plan:	Yes	No	N/A
43. Initial Client Plan done by 60 days of episode opening date. (Level 3 by 4th visit)	☐	☐	☐
44. Annual Client Plan completed on time. (Applicable to charts on an Annual Authorization Cycle)	☐	☐	☐
45. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.)	☐	☐	☐
46. Client Plan is consistent with diagnosis.	☐	☐	☐
47. Mental Health Objectives are specific, observable, and/or measureable with timeframes.	☐	☐	☐
48. Client Plan identifies proposed service modalities, their frequency and timeframes.	☐	☐	☐
49. Client Plan describes detailed provider interventions for each service modality listed in the Plan.	☐	☐	☐
50. Client's Risk(s) have a safety plan (DTO, Harm to Self, at risk for DV, Abuse, etc.)	☐	☐	☐
51.Plan signed/dated by LPHA	☐	☐	☐
52.Plan signed/dated by MD, if provider prescribes MH Rx.	☐	☐	☐
53. Coordination of care is evident, when applicable.	☐	☐	☐
54. Client Plan signed/dated by client or legal representative when appropriate or documentation of client refusal or unavailability.	☐	☐	☐
55.Client Plan indicates client indicates the client/representative was offered a copy of the Client Plan	☐	☐	☐
56.Client Plan contains Tentative Discharge Plan	☐	☐	☐

Progress Notes:			
57.There is a progress note for every service contact	☐	☐	☐
58.Correct CPT & Insyst service code	☐	☐	☐
59.Date of service	☐	☐	☐
60.Location Listed & Correct	☐	☐	☐
61. Face-to-Face & Total times are documented	☐	☐	☐
62.Notes for Ct encounters incl. that day's evaluation/ behavioral presentation	☐	☐	☐
63.Notes for Ct. encounters include that day's Staff Intervention	☐	☐	☐
64. Notes for Ct. encounters incl. that day's Ct. response to Intervention.	☐	☐	☐
65.Notes for Ct. encounters incl. Ct &/or Staff f/u plan	☐	☐	☐
66.Group service notes include # of clients in attendance	☐	☐	☐
67. Services are related to the current Client Plan's Mental Health objectives.	☐	☐	☐
68.Unresolved issues from prior services addressed, if app.	☐	☐	☐
69. Signed & dated with designation: Licensed/Registered/Waivered/MHRS/Adjunct	☐	☐	☐
70. Completion line at signature (n/a for electronic notes).	☐	☐	☐
71. Service provided while Ct. was not in lock-out setting, IMD, or Jail.	☐	☐	☐
72. Service provided was NOT SOLELY for supervision, academic educational services, vocational services, recreation, and/or socialization.	☐	☐	☐
73. Service provided was NOT SOLELY transportation.	☐	☐	☐
74.Service was NOT SOLELY clerical			
75.Service was NOT SOLELY payee related			
76.Progress note was completed within the required timeframe per MHP	☐	☐	☐
77.Progress note documents the language that the service is provided in, as needed	☐	☐	☐
78.Progress note indicates interpreter services were used, and relationship to client is indicated, as needed	☐	☐	☐
79. E/M progress note is compliant with E/M documentation standards.	☐	☐	☐

Comments/Feedback:

Reviewer:	**Date:**