alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ACBH SUD Full Medical Necessity CQRT Tool (OS/IOS/RSS/WM/RES)

Client Name: | SUD ASAM LOC:

Date of Next CQRT: | InSyst/PSP#: | EOD:

Clinician Review Components (Use comments sheet)

Informing Materials/Releases	Yes	No	N/A		Yes	No	N/A
1. InSyst or CG Face Sheet accurate (e.g. EOD, provider, RU) w/current SUD included diagnosis(es)	☐	☐	☐	29. Criminal history, legal status, treatment history assessed	☐	☐	☐
2. *ACBH Informing Materials/Consent to Treat* signature page complete and signed by intake/assessment due date and then annually.	☐	☐	☐	30. Client risks assessed (relapse, DTO/DTS)	☐	☐	☐
3. *SUD Programs ROI* signed by opening date of services	☐	☐	☐	31. SOGIE information gathered (or indicated plan to assess)	☐	☐	☐
4. When prescribing, valid informed consent for medication(s) present	☐	☐	☐	32. Language preference assessed at intake	☐	☐	☐
Medical Necessity (for Auth/Review Period)	**Yes**	**No**	**N/A**	33. Intake/Assessment completed by a staff with the credentials to do so and within their scope of practice/training Reg. Counselor requires 50%	☐	☐	☐
5. IMN/CSJ relevant to review period was complete within required time frame. For initial: 5 days for residential, & 30 days for OS/IOS/RSS SUD programs. Cont. Just. of Services is due 5-6 months from EOD or date of last CSJ.	☐	☐	☐	34. If SUD counselor completed Intake/Assessment, LPHA reviewed and co-signed within 15 days	☐	☐	☐
				35. Assessment includes a detailed formulation	☐	☐	☐
				36. Assessment updated when applicable	☐	☐	☐
6. SUD diagnoses for treatment are on *ACBH SUD DMC Included Diagnosis* list	☐	☐	☐	**Client Plan (or Plans) Relevant to the Review Period**	**Yes**	**No**	**N/A**
7. Written basis on IMN/CSJ supports each SUD diagnosis to be treated (specific, individualized, and with time frames).	☐	☐	☐	37. All challenges identified in the assessment are addressed in relevant plans or deferred (with explanation for deferral)	☐	☐	☐
8. SUD diagnoses established by LPHA. Unlicensed LPHA requires licensed LPHA co-signature within IMN/CSJ due date.	☐	☐	☐	38. Plan(s) includes goals to be reached that addresses each challenge	☐	☐	☐
9. LPHA establishing the diagnosis met face-to-face or telehealth with beneficiary or SUD Counselor who conducted the intake assessment (for initial) or primary SUD Counselor (for CSJ)	☐	☐	☐	39. Goals/Action Steps in plan are consistent with impairment to functioning and need for SUD treatment	☐	☐	☐
10. ALOC(s) relevant to review period completed within required time frame. ALOC Initial: WM 3.2 48 hrs, RES by day 5, and OS/IOS/RSS providers by day 30. ALOC Review: RES every 30 days, IOS every 60 days, OS every 90 days, RSS every 6 months from EOD	☐	☐	☐	40. Action Steps are specific, measurable, attainable, realistic, observable, and with target dates	☐	☐	☐
				41. Plan(s) include service descriptions (type of counseling) and frequency	☐	☐	☐
11. All pertinent elements of ALOC(s) include description	☐	☐	☐	42. Plan(s) include ICD-10 code and DSM-5 name of diagnosis	☐	☐	☐
12. For each relevant ALOC, indicated ASAM LOC matches client's presentation at the time of completion	☐	☐	☐	43. Plan(s) are consistent with diagnosis and medical necessity (golden thread).	☐	☐	☐
13. When referred to a LOC that is different than assessed the LOC there is a valid description of the reason for the difference	☐	☐	☐	44. If physical exam indicates sig. illness, plan(s) includes goal for tx	☐	☐	☐
14. For Cont. Just. of Services, Recommendation is complete.	☐	☐	☐	45. If client has not had a physical exam in past 12 months, plan(s) include a goal to get an exam	☐	☐	☐
15. For Residential (RES) UM preauthorization completed and documents filed in chart (N/A if OS/IOS/RSS)	☐	☐	☐	46. Client's risk(s) have a safety plan: Relapse, (DTS/DTO), at risk for DV/IPV, Abuse, etc.	☐	☐	☐
Medical	**Yes**	**No**	**N/A**	47. Plan(s) indicates who is client's "primary" counselor/LPHA	☐	☐	☐
16. Physical exam requirements are met: 1) Exam completed by provider, 2) Client had one in the past 12 months – provider has documentation of this or gets it prior to the plan being completed, or 3) No physical and a goal is in the plan to get one.	☐	☐	☐	48. Plan(s) revised when significant change (e.g. in service, diagnosis, focus of treatment, inaccurate frequency, etc.).	☐	☐	☐
				49. Coordination of care is evident, when applicable	☐	☐	☐
17. Physical exams completed by external health providers meet agency exam requirements as evidenced by agency review (MD, PA, or NP)	☐	☐	☐	50. Plan(s) contain *Tentative Discharge Plan*	☐	☐	☐
18. Allergies/adverse reactions/sensitivities or lack thereof noted prominently on charts' cover or in EHR	☐	☐	☐	51. Plan(s) include complete signature of plan author (LPHA or Counselor); printed name, signature, credentials, date	☐	☐	☐
19. AOD programs have completed Health Questionnaire (DHCS 5103)	☐	☐	☐	52. Plan(s) relevant to review period complete within required time frames: For initial 48hrs WM 3.2, 10 days RES, & 30 days for OS/IOS/RSS SUD services. Then at least every 90 days from author (LPHA or Counselor) signature date. Initial plan cannot be completed prior to establishment of medical necessity.	☐	☐	☐
Assessment	**Yes**	**No**	**N/A**				
20. Intake Assessment is complete within required time frames: 48hrs for WM 3.2, 10 days for residential, and 30 days for IOS/OS/RSS	☐	☐	☐				
21. All required elements of Intake Assessment are complete	☐	☐	☐	53. Plan(s) signed/dated by client (or legal representative when appropriate) or documentation of client refusal or unavailability within required time frames. Initial by plan due date & updates 30 days from author signature date.	☐	☐	☐
22. Drug/alcohol use, history assessed (may not be deferred)	☐	☐	☐				
23. Medical history assessed	☐	☐	☐	54. Plan(s) completed by SUD Counselor has LPHA co-signature within 15 days of plan author signature.	☐	☐	☐
24. Psychiatric/psychological history assessed	☐	☐	☐	**Review a minimum of 6 Progress Notes. If there are not 6 notes, then last 30 days.**			
25. Social/recreational history assessed	☐	☐	☐	**Progress Notes (ALL Programs)**	**Yes**	**No**	**N/A**
26. Financial status/history assessed	☐	☐	☐	55. There is a note for each claim or for RES/WM 3.2 each day claimed	☐	☐	☐
27. Educational history assessed	☐	☐	☐	56. Notes include service date	☐	☐	☐
28. Employment history assessed	☐	☐	☐	57. Notes indicate location of service: in-person, telephone, telehealth	☐	☐	☐
				58. Notes include info on the beneficiary's attendance, including the date, start and end times of each service	☐	☐	☐

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	Yes	No	N/A
59. Notes have face-to-face, travel, and total times documented	☐	☐	☐
60. Notes include the topic or purpose of the session (RES daily must include this for all services that day)	☐	☐	☐
61. Planned service codes claimed are in applicable plan or plans (initial exceptions may apply) *RES and WM 3.2 only need RES Day	☐	☐	☐
62. Notes use correct procedure code. Review the procedure codes used and the content of the note. Note must have code or exact name.	☐	☐	☐
63. Services are related to the current client plan goals	☐	☐	☐
64. Notes include a description of progress on client plan problems, goals, action steps, objectives, and/or referrals	☐	☐	☐
65. Notes for client encounters include client and/or staff follow-up plan	☐	☐	☐
66. Community services indicate how provider ensured confidentiality	☐	☐	☐
67. Notes are individualized and with minimal copy/paste.	☐	☐	☐
68. Notes include legibly printed name, signature, credentials, & date	☐	☐	☐
69. Notes are completed by due date (7 days, except *RES Weekly Summary* which is due the next calendar week from the service)	☐	☐	☐
70. Documentation time is reasonable, substantiated by content, & w/date	☐	☐	☐
71. Services provided by allowable staff within their scope of practice	☐	☐	☐
72. Services provided utilize one of the following EBPs: MI, CBT, Trauma-Informed Treatment/Seeking Safety, or a contract specific EBP.	☐	☐	☐
73. Services were provided by staff with valid credentials to do so at the time of the service	☐	☐	☐
74. Medication Services provided are within established requirements	☐	☐	☐
75. Physician Consultation services are between agency physician and ACBH specified physician consultant	☐	☐	☐
76. Notes document the language that the service is provided in	☐	☐	☐
77. Notes indicate when interpreter services were used, and relationship to client is indicated, as needed	☐	☐	☐
78. Services provided do not include time claimed for non-billable activities, such as: supervision, academic, educational services, vocational services, recreation, UA lab fees, socialization, discharge summary, clerical, administrative, voicemails, no-shows, interpretation, etc.	☐	☐	☐
79. Services provided while client was not in lock-out setting, jail, JH (youth w/out adjudication)	☐	☐	☐

Progress Notes (RES ONLY)	Yes	No	N/A
80. 3.1 ≥ 15 mins a day; 3.3/3.5 ≥ 1 hour a day → client must be sleeping in the bed that night	☐	☐	☐
81. 20 hours of structured therapeutic activities documented per week	☐	☐	☐
82. 3.1 ≥ 5 hours a week; 3.3/3.5 ≥ 12 hours a week → over 5 days within a 1 week period	☐	☐	☐
83. Time claimed in notes only includes RES reimbursable activities	☐	☐	☐
84. A narrative summary of progress on client plan, problems, goals, action steps, objectives, and/or referrals is complete either every day or at a minimum weekly.	☐	☐	☐
85. Transportation is for providing and coordinating transportation. Note CM does not include transportation and staff must accompany when claiming for transportation time	☐	☐	☐

Progress Notes (WM 3.2 ONLY)	Yes	No	N/A
86. WM 3.2 services are only intake, observation, medication services, care coordination, treatment planning, and discharge services.	☐	☐	☐
87. Observations & physical checks documented every 30 minutes for the first 72 hours following admission? (Exceptions allowed after 24 hrs).	☐	☐	☐
88. Documentation of observations and physical checks includes printed name, signature, credentials, and date	☐	☐	☐

Group Notes/Sign-In Sheets	Yes	No	N/A
89. Group notes include co-facilitator's name, credentials, signature, date, and face-to-face time only	☐	☐	☐
90. There is a group sign-in sheet for every group counseling session or group patient education session	☐	☐	☐
91. Group sign-in sheets indicate the number of participants	☐	☐	☐
92. Group sign-in sheets include the topic of the session	☐	☐	☐
93. Group sign-in sheets includes the date and start/end time (if different for client, this is indicated)	☐	☐	☐
94. Group sign-in sheets includes for each attendee, their legibly printed name & signature	☐	☐	☐
95. SUD Counselor/LPHA who conducted group legibly printed their name and signed sign-in sheets	☐	☐	☐
96. Adults are not in groups with beneficiaries 17 or younger unless at a certified school site	☐	☐	☐

Perinatal / Parenting Services	Yes	No	N/A
97. Additional perinatal assessment items completed	☐	☐	☐
98. Regularly scheduled UA Screening is documented "to reduce harm"	☐	☐	☐
99. Child Care services are included in the Client Plan and/or Wait List	☐	☐	☐
100. Child Care addresses therapeutic and developmental needs noted in assessment	☐	☐	☐
101. Parenting Skills and Relationship Building are included in the Client Plan	☐	☐	☐
102. Referrals to Community Services "Outreach" are documented	☐	☐	☐
103. Client record contains medical documentation of pregnancy or birth	☐	☐	☐

Youth Services	Yes	No	N/A
104. Assessment includes evaluation of developmental & cognitive functions	☐	☐	☐
105. Safety Issues are identified and include follow-up	☐	☐	☐
106. Alcohol and Drug testing schedule is documented	☐	☐	☐
107. IOS/RES Client Plan includes therapeutic (art therapy, writing) & diversionary recreation activities (physical health, stretching, sports).	☐	☐	☐
108. Client Plan includes Educational Sessions i.e., Nutrition, Addiction, HIV/AIDS, TB, STD, Hepatitis	☐	☐	☐
109. Efforts to involve family or other support persons are documented & included in the Client Plan	☐	☐	☐

Chart Overview	Yes	No	N/A
110. Additional Releases of information (ROIs), when applicable	☐	☐	☐
111. *ROI Tracker Log* is present and completed when client information is released	☐	☐	☐
112. Emergency contact information up to date with ROIs	☐	☐	☐
113. Emergency Info. Is in a designated location in file/EHR/InSyst	☐	☐	☐

Each **NO** must have a comment. Use *ACBH SUD Med Necessity CQRT Tool Comment Sheet* for comments.

CQRT Reviewer Signature/Credentials:_____ Date:_____
*Reviewer signature is always required (if the chair is the reviewer, sign here and once CQRT is complete, chair signs below)

CQRT Chair Signature/Credentials:_____ Date:_____
*Chair signature is required <u>after</u> CQRT process is complete.

By signing this document, I attest that, as CQRT chair, to the best of my knowledge, all applicable ACBH standards have been met and/or corrected. Additionally, at the time of this attestation this chart is in compliance with relevant SUD documentation standards and services meet medical necessity.

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