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| Complete all of the following: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. CQRT Date: | | |  | | | | | | | | | | | | | | | | | 5. Reporting Unit: | | | |  | | | | | | | | | | | | |  | |
| 2. Client Name: | | | |  | | | | | | | | | | | | | | | | 6. Primary: | | |  | | | | | | | | | | | | | |  | |
| 3. Client InSyst #: | | | | |  | | | | | | | | | | | | | | | 7. Episode Opening Date: | | | | | | | | |  | | | | | | | |  | |
| 4. Provider Name: | | | | |  | | | | | | | | | | | | | | | 8. SUD Program Type: | | | | | |  | | | | | | | | | | |  | |
|  | | | | | |  | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | |  | |
| 9. **OS/IOS Substance Use Disorder Services request** as indicated on treatment plan (check all that apply): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual Counseling | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Group Counseling | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Medication Services | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Family Therapy (LPHAs Only) | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Collateral Services | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Patient Education (Grp/Ind) | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Group Multi-Family Counseling - ADOL | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
|  | | | | | | | | | | | | |  | |  | | | | | | |  | | | | | |  | | | | | | |  | |  | |
| **Withdrawal Management Services request** as indicated on treatment plan (check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Observation | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Medication Services | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
|  | | | | | | | | | | | | |  | |  | | | | | | |  | | | | | |  | | | | | | |  | |  | |
| **Recovery Support Services request** as indicated on treatment plan (check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Individual Counseling | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Group Counseling | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Recovery Service Monitoring/SAA | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
|  | | | | | | | | | | | |  | | | | |  | | | |  | | | |  | | | | | | | | | | |  |  | |
| 10. **Case Management Services request** as indicated on treatment plan (check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Case Management: Care Coordination | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
| Case Management: Service Coordination | | | | | | | | | | | | | Frequency: | | | |  | | | | | and As Needed | | | | | | Duration: | | | | | | |  | |  | |
|  | | | | | | | | | | | | |  | |  | | | | | | |  | | | | | |  | | | | | | |  | |  | |
| 11. **Medical Necessity** (both required for medical necessity): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Included SUD Diagnosis with individualized written basis (LPHA completing the diagnosis and written basis must meet face-to-face or via telehealth with beneficiary or SUD counselor who completed the assessment. Unlicensed LPHAs must have licensed LPHA co-signature) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | ASAM Level of Care (ALOC). May be completed by SUD counselor or LPHA. Differences in LOC and placement must have clinical explanation. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. Primary Counselor/LPHA: | | | | | | | | |  | | | | | | | | | | Recommend Approval:  Yes  No | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | Signature/Credentials | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| 13. Agency Supervisor: | | | | | | | |  | | | | | | | | | | | Recommend Approval:  Yes  Pending (30 Day Return)  No | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | Signature/Credentials | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| 14. CQRT Reviewer **(REQUIRED):** | | | | | | | | | | |  | | | | | | | | Recommend Approval:  Yes  Pending (30 Day Return)  No | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | Printed Name | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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|  | Signature/Credentials (LPHA or Certified SUD Counselor) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Date | | | | | |  |
| 15. CQRT Chair **(REQUIRED):**  Full Authorization–Start Date: | | | | | | | | | | | | | | | | | |  | | | | | | | | | End Date: | | | | | | |  | | | |  |
| Returns:  Authorization pending return in 30 Days, by this date: | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  |
| No Authorization for DMC-ODS Services, chart to be returned to CQRT, by this date: | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  |
| CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | |  | |  | | | | |  |
|  | CQRT Chair Signature (Must be Licensed LPHA) | | | | | | | | | | | | |  | | InSyst ID | | | | | | | | | | | | | | |  | | Date | | | | |  |

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| **Use this Addendum if Chart is to be returned** | | | | | | | | | | | | | | | | | | | | |
| **1st Return** | | | | | | | | | | | | | | | | | | | | |
| Primary Counselor/LPHA Comments: | | | | | | | | | | | | Supervisor Comments: | | | | | | | | |
| Primary LPHA/Counselor: | | | | | | | |  | | | | | Recommend Approval:  Yes  No | | | | | | | |
|  | | | | | Signature/Credentials | | | | | | |  | | | | | | | | |
| Agency Supervisor: | | | |  | | | | | | | | | Recommend Approval:  Yes  Pending (30 Day Return)  No | | | | | | | |
|  | | | | | |  | | | | | |  | | | | | | | | |
| CQRT Reviewer or Chair Comments: | | | | | | | | | | | | | | | | | | | | |
| CQRT Reviewer: | | |  | | | | | | | | | | Recommend Approval:  Yes  Pending (30 Day Return)  No | | | | | | | |
|  | | Signature/Credentials (must be a Licensed, Registered or Waivered LPHA) | | | | | | | | | | | | | | | | | | |
| CQRT Chair:  Full Authorization–Start Date: | | | | | | | | |  | | | | | End Date: | | | | |  |  |
| Returns:  Authorization pending return in 30 Days, by this date: | | | | | | | | | | | | | | | | | |  | |  |
| No Authorization for SUD DMC-ODS Services – Chart to be returned to CQRT, by this date: | | | | | | | | | | | | | | | |  | | | |  |
| CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period). | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | |  |  | | | |  | | | |  |  |
|  | CQRT Chair Signature/License: | | | | | | | | |  | InSyst ID | | | |  | | | | Date |  |
| **2nd Return** | | | | | | | | | | | | | | | | | | | | |
| Primary Counselor/LPHA Comments: | | | | | | | | | | | | Supervisor Comments: | | | | | | | | |
| Primary LPHA/Counselor | | | | | | |  | | | | | | Recommend Approval:  Yes  No | | | | | | | |
|  | | | | | Signature/Credentials | | | | | | |  | | | | | | | | |
| Agency Supervisor: | | | |  | | | | | | | | | Recommend Approval:  Yes  Pending (30 Day Return)  No | | | | | | | |
|  | | | | | |  | | | | | |  | | | | | | | | |
| CQRT Reviewer or Chair Comments: | | | | | | | | | | | | | | | | | | | | |
| CQRT Reviewer: | | |  | | | | | | | | | | Recommend Approval:  Yes  Pending (30 Day Return)  No | | | | | | | |
|  | | Signature/Credentials (must be a Licensed, Registered or Waivered LPHA) | | | | | | | | | | | | | | | | | | |
| CQRT Chair:  Full Authorization–Start Date: | | | | | | | | |  | | | | | End Date: | | | | |  |  |
| Returns:  Authorization pending return in 30 Days, by this date: | | | | | | | | | | | | | | | | |  | | |  |
| No Authorization for SUD DMC-ODS Services – Chart to be returned to CQRT, by this date: | | | | | | | | | | | | | | | |  | | | |  |
| CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period). | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | |  |  | | | |  | | | |  |  |
|  | CQRT Chair Signature/License: | | | | | | | | |  | InSyst ID | | | |  | | | | Date |  |