

Alameda County Behavioral Health Services

CQRT Manual

Presented by the Quality Assurance Office

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CQRT Overview

The Clinical Quality Review Team (CQRT) is a group that meets regularly to review clinical records for documented evidence of medical necessity for outpatient specialty mental health services (SMHS) that are provided to Alameda County beneficiaries of the Medi-Cal Mental Health Plan (MHP).¹ The purpose of these reviews is to provide payment authorization for ongoing SMHS and to ensure that clinical documentation standards are met. This Manual describes the BHCS-operated CQRT process.

Per DMH Information Notice 02-06, contracted organizations that provide the following services are required to obtain payment authorization through the BHCS-CQRT:

- Day treatment services
- Outpatient SMHS delivered concurrently to day treatment (supplemental authorization)
- Therapeutic Behavioral Services (TBS)

In addition, newly contracted organizational providers, providers with corrective action plans, or providers with additional contractual obligations are required to attend a BHCS-CQRT meeting for a period of time designated by the MHP.

Although BHCS authorization is not required for other providers of outpatient SMHS, those providers will perform an internal review process to assure they maintain compliance to any and all contractual requirements. A licensed, waived, or registered LPHA will continue to approve Treatment/Client Plans, but will not submit them for BHCS authorization. Those providers are encouraged to model their internal review process after the review requirements in this Manual. Providers should maintain documentation of their internal review process.

Starting CQRT

New Programs

Organizational providers with previous CQRT experience in Alameda County do not participate in CQRT; if they develop new programs, they are incorporated into the provider's internal CQRT. It is the expectation that the existing, organizational provider has sufficient experience to train their new staff. The exception is when that CBO is adding a program with different/new documentation requirements with which they are unfamiliar, e.g., Day Treatment Intensive/Rehab or TBS.

New Programs that are not part of an existing, contracted organizational provider and that are not bringing beneficiaries from another program (slow start) will begin attending CQRT at 3 months. At that time they will:

- Review treatment plans and progress notes, etc., and will do complete, quality chart reviews for 3 months.
- At 6 months they begin attending the New Program CQRT with standard participation, bringing their own charts for 12 months.

Existing programs changing from Fee-for-Service to contracted CBO:

- At 3 months, QA will do an in-house CQRT where the provider reviews their own charts with QA staff present for 1 full day.
- At 6 months, they will attend the New Program CQRT with charts due each month for 12 months.

Please refer to the BHCS Quality Assurance Manual for a complete description of clinical record documentation standards. The BHCS-QA website (www.acbhcs.org/providers then under the QA tab) is very informative and has documents, policies and manuals available to download.

Supporting regulations for requirements in this Manual are cited in the Appendix.

If you have questions that are not addressed in this Manual or at the BHCS-QA website, please first consult with your clinical supervisor or your organization's quality assurance staff. If your organization does not have someone responsible for quality assurance, please consider appointing one or two staff to receive and disseminate QA information so that it stays internally consistent and so that you are able to filter BHCS requirements through your own program's priorities & needs – in other words, you are able to create & enforce requirements that are more strict than BHCS's, but that may better suit your unique needs.

If questions remain unanswered, a provider's Quality Assurance staff or clinical supervisor may contact the BHCS Quality Assurance Office at (510) 567-8105.

Section I: How to Get Specialty Mental Health Services Reviewed for Reimbursement

Initial Review & Approval

The initial period of approval for reimbursement of services begins with the opening of a client's episode in the PSP system (see InSyst Manual) by data entry staff. That staff then enters an initial period of service authorization for either 3 or 6 months, depending on the type of provider program (see below).

A program's clinical staff must complete the Initial Assessment within 30 days of a client's episode opening date (EOD; aka admission date).

Exceptions:

- Full Service Partnership (FSP) programs & BHCS-identified "Brief Service Programs" must complete the Initial Assessment within 60 days of a client's EOD.
- Time-limited programs under 3 months in duration must complete the Initial Assessment by the seventh (7th) day from the client's EOD.

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The completed Initial Assessment determines whether there is medical necessity for ongoing services. If there is no medical necessity, the client's episode is closed. If medical necessity is documented and services will be provided, the client's episode remains open.

On 11/1/10, Alameda County BHCS instituted a 60-day deadline for the Initial Client/Treatment Plan, counted from the EOD. Providers receive an InSyst prompt for this deadline date, and prompts every 6 months thereafter, to create Initial and ongoing Client Plans. (Prior to 11/1/10, the Initial Client Plan deadline was 30 days from the EOD.)

Exceptions:

Time-limited programs under 3 months in duration must complete the Client/Treatment Plan by the fifteenth (15th) day of treatment.

The length of the initial approval period depends on the type of provider program; charts are then reviewed for approval via the CQRT as follows:

- **Outpatient Mental Health Services:** Initial approval is done by the provider program for the first 6 months & every 6 months thereafter.
- **Adult Day Treatment—Rehabilitative & Intensive:**
 - **Programs more than 6 Months in Duration:** Initial approval is requested no later than 60 days from the episode opening date. The authorization will cover 6 months from the first day of the month that the episode was opened, e.g., start date 8/8/11; fax by 10/7/11; authorized 8/1/11 to 1/31/12.
 - **Time-limited Programs 3 – 6 Months in Duration (90 – 179 days):** Initial authorization is requested no later than 30 days from the opening episode date. The authorization will cover 3 months from the first day of the month that the episode was opened. (e.g., start date 8/8/11; fax by 9/7/11; authorized 8/1/11 to 10/31/11)

- *Time-limited Programs under 3 Months in Duration (45 – 89 days):* Initial authorization is requested no later than the seventh (7th) day from the episode opening date. The authorization will cover 30 days from the episode opening date, e.g., start date 8/8/11; fax before 8/15/11; authorized 8/8/11 to 9/7/11. The CQRT/authorization at 30 days will authorize for 60 days, e.g. fax before 9/7/11; authorized from 9/8/11 to 11/6/11. **Note:** For programs under 3 months, Assessments are due by the 7th day from EOD and Client/Treatment Plans are due by the 15th day from EOD.¹
- *Children's Rehabilitative Day Treatment:* CQRT provides initial approval at the first CQRT meeting after the expiration of the 60-day treatment plan approval date, then 6 months from the first day of the month that the episode was opened & every 6 months thereafter.
- *Children's Intensive Day Treatment: Initial Placement Authorization of the first 3 months by BHCS Children's Specialized Services* is required (see BHCS provider's website for more information); approval is required every 3 months thereafter. **Note:** Although these charts are reviewed every 3 months, Client/Treatment Plans are completed every 6 months.
- *Full Service Partnerships:* Authorization by the Crisis Response Program is required prior to a client's enrollment in the program. Thereafter, follow the process for your program type listed above.

This Manual will generally refer to 6-month approval periods to simplify the material; Intensive and Rehabilitative Day Treatment programs should keep in mind their respective time frames.

¹ This procedure and timeline is to facilitate compliance regarding the Quality Review process.

Chart Review Cycle

As just noted, the months in which a specific chart must be reviewed depends on 1) the type of provider program and 2) the month of the client's episode opening date (EOD). This timing of chart review is referred to as the chart's "CQRT review cycle." It is essential to understand how to determine review cycles for proper authorization of ongoing services. Use the calendar below while reading the following examples of chart cycles below.

January 2007

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
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February 2007

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March 2007

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April 2007

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May 2007

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June 2007

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July 2007

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August 2007

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September 2007

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October 2007

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November 2007

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December 2007

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Example: Outpatient and Rehab Day Treatment (not time-limited) chart review cycle (every 6 months)

Episode Opening Date = February 17, 2007

First "review cycle" starts February 1 and goes through July 31 (the end of the 6th month).

This chart's first CQRT review is done in July & every 6 months thereafter (July, January, July, etc.), to allow for authorization starting on the 1st of the following months.

This chart's CQRT review cycle will always be January/July for authorization starting February 1 and August 1.

Example: Children Intensive Day Treatment chart review cycle (every 3 months)

Episode Opening Date = February 17, 2007

First "review cycle" starts February 1 and goes through the end of the 3rd month (April 30). This chart's first CQRT review (by BHCS) is in April & every 3 months thereafter (July, October, January, April, July, etc.), to allow for authorization starting on the 1st of the following months.

This chart's CQRT review cycle will always be January/April/July/October for authorization starting February 1; May 1; August 1; October 1

Example: Day Treatment Rehab Time-limited 3-6 months (every 3 months)

Episode Opening Date = February 17, 2007

Initial Authorization requested no later than March 18, 2007.

First “review cycle” starts February 1 and goes through the end of the 3rd month (April 30). This chart’s first CQRT review (by BHCS) is in April.

As shown in the examples, charts must be reviewed by the CQRT in the month **before** the next review cycle begins, so that services for the following period can be authorized. If a chart is brought to the CQRT or sent to Authorization Services later than its scheduled review, there is a risk of not getting authorization for the interim services.

- **Exception:** Time-limited programs may have review cycles set specifically to those programs.

The review cycle for each chart always stays the same based on the EOD, regardless of the approval period. This is very important in order to ensure timely authorization of services and to ensure that InSyst prompts are correct. Therefore, the cycle stays the same even if a chart is given a 1-month authorization because of documentation deficiencies. If a chart is closed and then re-opened, the review cycle and the timing of treatment plans will change to follow the new episode opening date.

The review cycle is always calculated using the first day of the month in which the episode was opened, regardless of the actual start date – and it always stays the same for that chart.

(Exception: Time-limited programs may have review cycles set specifically to those programs.)

Client/Treatment Plan Cycles

The timing of when Client/Treatment Plans are done must be relative to the CQRT review cycle. This is because the CQRT must have a recently completed Client Plan in order to determine ongoing medical necessity. Again, it is helpful to view a calendar while reading an example.

January 2007

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February 2007

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March 2007

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April 2007

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May 2007

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June 2007

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July 2007

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August 2007

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September 2007

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October 2007

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November 2007

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December 2007

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Example: An Outpatient client's EOD is 10/29/07. The Initial Assessment is completed prior to 11/29/07. The Initial Client/Treatment Plan is completed by 12/27/07.

(BHCS changed to a 60-day deadline for the Initial Client Plan on Nov. 1, 2010; this example is based on that change but refers to the 2007 calendar as a sample). (Exception: *Day Treatment Intensive/Rehabilitative Programs with less than 3 months duration*. Assessments for these programs have a 7 day deadline and Client/Treatment Plans have a 15 day deadline, e.g. EOD and 1st day of treatment is 10/29/07. The Initial Assessment is completed by 11/06/07. The Initial Client/Treatment Plan is completed by 11/16/07.)

The next Client Plan is the 6-month revision, or a Client Plan Update. Though the Initial Client Plan is done in November or December, the Client Plan Update is completed 6 months from the episode opening **month** (October, in this example), **not** 6 months after the Initial Client Plan. Therefore, in this example, the Client Plan Update is completed just prior to 3/29/08.

The following Plan will be a new Annual Client Plan, done 6 months later in September, and every year thereafter just prior to the anniversary of the client's EOD month. Here is the Client Plan sequence: Initial Client Plan, Client Plan Update, Annual Client Plan, Client Plan Update, etc.

As the example on Page 5 notes, you must use the episode opening date (for the Initial Plan) and month (for all other Plans) to determine each Client plan's timing, so that future Plans will be completed in the month of the CQRT meeting. This is because it must be reviewed by the CQRT before the next approval period begins, therefore it must be in the chart and already approved by a licensed, waived, or registered LPHA² when brought to the CQRT meeting.

- If episodes are closed and then re-opened, the Client Plan cycles must coordinate with the new EOD.
- If existing providers change their contract status with BHCS, client EOD's are re-set by the County. In this situation, a new Client Plan cycle must be initiated to coordinate with the new EOD.

Date of Client Plan Signatures

Client Plans are written and finalized "just prior to" a date determined by the client's EOD. The LPHA (licensed, waived, or registered) signature date is what determines whether a Client Plan was finalized on time. A Client Plan may be developed and written prior to its due date, but the Plan's information must be up-to-date at its due date.

- If a Plan is amended after signatures are obtained, the signatures are invalidated and must be obtained again.

(See the next section for more information about Client Plan signatures; also see QA Manual, Documentation Standards for complete requirements at www.acbhcs.org/providers, under the QA tab.)

Client Plan Addendums

A Client Plan Addendum must be written whenever there is a significant change in services provided, treatment focus, diagnosis, objectives, etc. and can be just a sentence or two added to an existing Plan. Regardless of when an Addendum is done, an Annual Client Plan and Update must still be done according to that chart's CQRT review cycle.

Example: An Outpatient Services chart with a January/July review cycle needs an addendum to the Client Plan in June due to a significant change in the primary focus of treatment. Even though the addendum is done in June, a Client Plan Update will still need to be done in July in order to stay on cycle.

The next page shows an example of one outpatient chart's CQRT review cycle, along with its Client Plan cycle, to demonstrate how the EOD affects both processes. Pages 8 and 9 show annual timetables by month of episode opening for different program types.

Outpatient Example of a CQRT Review Cycle & its Client Plan Cycle

Client's episode opening date: August 29

Initial Review by Program

Initial Client Plan completed within 60 days
of the episode opening date, or by: October 27

First 6-month authorization period: August 1 – January 31

1st CQRT Review

Client Plan Update completed in January

CQRT review done in January

For service authorization of the 2nd period February 1 – July 31

This particular chart's CQRT review cycle will always be:

July: for August 1 - Jan. 31 approval

January: for Feb. 1 - July 31 approval

2nd CQRT Review

New Annual Client Plan completed in July

CQRT review done in July

For service authorization of the 3rd period August 1 – January 31

Outpatient & Rehabilitative Day Treatment (not for Time-Limited Programs):

CQRT Review/Client Plan Cycles
(Not including the Initial Client Plan)

EPIISODE OPENING MONTH	AUTHORIZATION PERIODS	CQRT REVIEW MONTHS	CLIENT PLAN CREATED & SIGNED IN:	CLIENT PLAN CREATED FOR:
January	Jan. 1 - June 30 July 1 - Dec. 31	June December	June Dec.	July 1st January 1st
February	Feb. 1 - July 31 Aug. 1 - Jan. 31	July January	July Jan.	August 1st February 1st
March	Mar. 1 - Aug. 31 Sept. 1 - Feb. 28	August February	Aug. Feb.	Sept. 1st March 1st
April	April 1 - Sept. 30 Oct. 1 - Mar. 31	September March	Sept. March	October 1st April 1st
May	May 1 - Oct. 31 Nov. 1 - Apr. 30	October April	Oct. April	Nov. 1st May 1st
June	June 1 - Nov. 30 Dec. 1 - May 31	November May	Nov. May	Dec. 1st June 1st
July	July 1 - Dec. 31 Jan. 1 - June 30	December June	Dec. June	January 1st July 1st
August	Aug. 1 - Jan. 31 Feb. 1 - July 31	January July	Jan. July	February 1st August 1st
September	Sept. 1 - Feb. 28 Mar. 1 - Aug. 31	February August	Feb. Aug.	March 1st Sept. 1st
October	Oct. 1 - Mar. 31 Apr. 1 - Sept. 30	March September	March Sept.	April 1st October 1st
November	Nov. 1 - Apr. 30 May 1 - Oct. 31	April October	April Oct.	May 1st Nov. 1st
December	Dec. 1 - May 31 June 1 - Nov. 30	May November	May Nov.	June 1st Dec. 1st

Intensive Day Treatment: CQRT Review/Client Plan Cycles
(Not including the Initial Client Plan and Not for Time-Limited Programs)

EPISODE OPENING MONTH	AUTHORIZATION PERIODS	CQRT REVIEW CYCLE	CLIENT PLAN CREATED & SIGNED IN:	CLIENT PLAN CREATED FOR:
January	Jan. 1 – March 31 April 1 - June 30 July 1 – Sept. 30 Oct. 1 - Dec 31	March June September December	June December	July 1 st January 1st
February	Feb. 1 – April 30 May 1 – July 31 Aug. 1 – Oct. 31 Nov. 1 – Jan. 31	April July October January	July January	August 1 st February 1st
March	March 1 – May 31 June 1 – Aug. 31 Sept. 1 – Nov. 30 Dec. 1 – Feb 28/29	May August November February	August February	September 1 st March 1st
April	April 1 – June 30 July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31	June September December March	September March	October 1 st April 1st
May	May 1 – July 31 Aug. 1 – Oct. 31 Nov. 1 – Jan. 31 Feb. 1 - April 30	July October January April	October April	November 1 st May 1st
June	June 1 – Aug. 31 Sept. 1 - Nov. 30 Dec. 1 – Feb 28/29 March 1 – May 31	August November February May	November May	December 1 st June 1st
July	July 1 - Sept. 30 Oct. 1 – Dec. 31 Jan. 1 - March 31 April 1 – June 30	September December March June	December June	January 1 st July 1st
August	Aug. 1 - Oct. 31 Nov. 1 - Jan. 31 Feb. 1 - April 30 May 1 - July 31	October January April July	January July	February 1 st August 1st
September	Sept. 1 - Nov. 30 Dec. 1 - Feb 28/29 March 1 - May 31 June 1 - Aug. 31	November February May August	February August	March 1 st September 1st
October	Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30 July 1 – Sept. 30	December March June September	March September	April 1 st October 1st
November	Nov. 1 – Jan. 31 Feb. 1 – April 30 May 1 – July 31 Aug. 1 – Oct. 31	January April July October	April October	May 1 st November 1st
December	Dec. 1 – Feb 28/29 March 1 – May 31 June 1 – Aug. 31 Sept. 1 – Nov. 30	February May August November	May November	June 1 st December 1st

Section 2: Chart Documentation & Preparing for the CQRT

The following is a list of items that should be easily located in any chart brought to the CQRT; it follows the Quality Review checklist located on the reverse side of the CQRT Review Form (see Appendix for both Children's & Adult versions; also available www.acbhcs.org/providers under the QA tab). The list is intended to assist clinicians to create and maintain a well-documented chart that meets the criteria for approval of ongoing services. This is a simplified guide to chart contents; all staff should refer to their program's policies and procedures for complete chart requirements and the BHCS QA Manual, Section 8 Policy on Documentation Standards (see above website).

- Contracted providers may modify BHCS document/form templates (see website), however it is the provider's responsibility to ensure that their forms contain, at a minimum, the elements listed in the Documentation Standards.
- County-operated programs must use the BHCS templates for all documents.

Evaluations & Consents:

All charts must contain the following forms for CQRT review, with all required signatures:

- Initial Assessment³ (completed within 30 days of episode opening date)
- Annual Community Functioning Evaluation* (at admission & annually thereafter)
- Informing Materials Packet's signature page (at admission & annually thereafter). This was distributed by BHCS to all providers in 2010 and addresses all required informing materials published by BHCS (see website).
- Consents for Release of Information, if applicable
- Medication Consents, if applicable

For clients under age 18, the chart must contain a comprehensive developmental history (including pre/perinatal), with an emphasis on social, emotional, psychological & cognitive development, and an assessment of the child's resiliency. The developmental history does not need to be located on the Assessment form; if that history is unavailable to the clinician, indicate this and the plan to obtain it, if possible. Also indicate factors that impair normal development, for example, trauma, illness or environmental/family stressors.

Client Plans:

All charts must contain Client/Treatment Plans⁴ that are based on the program's Assessment. The LPHA (licensed, waived, registered) signature date determines whether the Plan was finalized per that chart's cycle, as identified in the previous Section. If a client receives services from multiple programs within one provider agency, please see Section 4 of this manual for more information regarding Client Plans.

Initial/Annual Client Plan: Only selected plan elements are described below, as most are self-explanatory on the current BHCS template of this form. (Please check the www.acbhcs.org/providers site regularly for updated versions).

- DSM (current edition) Diagnosis⁵: A complete 5-axes diagnosis must be provided and substantiated by chart documentation. List each diagnosis separately and indicate the

primary diagnosis being treated. Indicate the name and credential of the clinician who determined the diagnoses and the date the diagnoses were established. In order to be covered by the MHP, the primary diagnosis must be an included diagnosis per the Specialty Mental Health Medical Necessity Guidelines (see Appendix; also www.acbhcs.org/providers, under the QA tab).

- Impairment Criteria and Service Necessity⁶: Document the signs and symptoms to support Axis I and Axis II diagnoses for treatment, as described by the DSM (current edition). The description must support impairment criteria -- how each identified impairment is a result of the primary diagnosis AND how the client's clinical presentation meets at least one of the following criteria:
 - Significant impairment in important area(s) of life functioning, or
 - Probability of significant deterioration in important area(s) of life functioning; or
 - Probability that a child will not progress developmentally as individually appropriate **AND** that the mental disorder can be corrected or ameliorated.

The documentation should also support service necessity by describing the client's level of current risk/stability/impairment in order to justify the type, frequency, and duration of the services currently being provided.

If a client is not making progress or has regressed in functioning, an explanation should be provided and treatment objectives should reflect interventions to address the identified issues.

If a client is stable but there is still risk of impairment, provide an explanation of the type and potential severity of the risk(s).

- Client Risk Assessment: Identify areas of risk associated with the client (i.e., danger to self/others, health, etc.) and what interventions are planned to reduce those risks, or reference the specific Client Plan objectives that address them. Data in this section should be consistent with descriptions of current areas of risk documented elsewhere in the clinical record. If there are no identified risks, note "N/A" to indicate that risk situations were assessed.
- Client Strengths & Resources: Describe these and, if applicable, how they are utilized in treatment to help achieve treatment objectives. This section should be updated annually.
- Special Needs: A client's cultural/linguistic and special visual/hearing needs should be identified and addressed in both the Initial Assessment and all Client Plans, including information provided and accommodations offered to address these needs. If there are no identified special needs, note "N/A" to indicate that an assessment was done.
- Medication Support Services: This section should contain complete information and be updated annually or whenever there is a change in psychotropic medications or service provision. Clients who **only** receive treatment from the program's psychiatrist must

have a “Medication Visit Only Treatment Plan” (template at www.acbhcs.org/providers), instead of the usual Client Plan, to be completed at the same prescribed intervals.

- Intervention Criteria: List the professional disciplines of program staff who provide services, the frequency of those services and the specific treatment modality, if applicable. For example, “Psychiatrist provides medication support 1x/month” or “Registered MSW provides individual therapy 1x/week”.

If a client receives services from more than one program, indicate which program staff provides each service (and document any collaborative efforts in progress notes). Service duplication will be *carefully* reviewed. See also Section 3 of this Manual about multiple providers.

If a client receives Therapeutic Behavioral Services (TBS), collaboration with the mental health provider of TBS must be indicated in each Client Plan as an Intervention, e.g., “Clinician will collaborate with TBS provider weekly”. Details of the collaboration will also be documented in the Progress Notes.

- Tentative Discharge Plan: Provide a month/year by which the client is expected to terminate services at your program. Indicate the clinical aftercare plan & referrals anticipated, given the expected improvements in functioning by that time.
- Client Goals: This section should reflect ongoing discussions with clients regarding their own goals, in their own words. It is expected that this section could change and impact the Client Plan objectives.
- Objectives⁷: These must be client-focused, measurable or observable, with timeframes, and must relate to the signs, symptoms and impairments that support the primary diagnosis for treatment. Specific interventions designed to help meet objectives should be included. Situational objectives (i.e., reunification, academic performance or job searches) should be framed from a clinical perspective related to the client’s symptoms/impairments. There may be objectives that are not clinical in nature, such as court-ordered activities, but the majority must be objectives relating directly to symptoms and impairments that are the focus of treatment. It is considered “best practice” to include the current baseline for each objective, as this provides easy identification of progress or the lack thereof, which may warrant modification of the Client Plan.

For example: “Area of Need: Client runs from the classroom when unable to tolerate increased anxiety. Objective: Within 6 months, Client will ask teacher for permission to take 2-minute break from classroom in 3/5 instances of escalating anxiety; currently does so in 1/5 instances.”

In this example, one intervention may involve helping the client identify early indicators of anxiety.

- **Participation & Agreement with the Client Plan⁸:** Demonstrated by the client and/or parent/guardian signatures on the Client Plan. If these signatures are not present, provide an explanation and describe the plan to obtain them (a notation of “unavailable” is not sufficient). Reference to a dated progress note which provides the explanation is acceptable. Please note that, because the Client Plan is not a legal document, the parent/guardian’s signature is only required if the client is unable to represent themselves. A minor client who is able to understand the concept of ownership (e.g., they know their “x” on a ball means the ball is theirs) is expected to sign the Client Plan regardless of their age.
- **Clinician Signatures⁹:** Required signatures include the treating clinician who wrote the Client Plan, the provider agency’s psychiatrist if medications are prescribed by that person, co-signature by a licensed, waived, or registered LPHA. If the clinician who wrote the Plan is licensed, a co-signature is not required. If the psychiatrist’s signature is provided, an additional LPHA signature is not required.

Client Plan Update: Done in the 6th month from the episode opening date and summarizes the client’s clinical status, progress toward meeting objectives, new objectives, and updates to any other Plan element. The BHCS template includes a section at the end for the Update (same signature rules apply).

Client Plan Addendum: A Client Plan Addendum must be written whenever there is a significant change in services provided, treatment focus, diagnosis, objectives, etc. and can be just a sentence or two added to an existing Plan. It may be a handwritten signed/dated paragraph added to a current Plan.

- If simply adding updated information about a client’s status, only the person writing the Addendum must sign.
- If making a change in the services provided, treatment focus, or Client Plan objectives, the client and other clinicians must re-sign. (Such a change invalidates previous signatures.)

Regardless of when an Addendum is done, an Annual Client Plan and Update must still be done according to that chart’s CQRT review cycle.

Progress Notes

Each progress note¹⁰ should indicate what has been done to assist the client toward the objectives identified in their Client Plan and should indicate ongoing medical & service necessity. Progress notes should be succinct, describe the clinically relevant service provided and how it relates to the objectives. There must be a progress note in the chart for each billable service. (Please see samples of acceptable and disallowed progress notes in the Appendix.)

A progress note should include, at minimum, the client's presenting problem or current status, interventions made by staff and the client's responses, clinical decisions, new assessment information, and the follow-up care (i.e., continue to address issue in ongoing sessions, collateral with residence staff, linkage to socialization group, etc.). A legible, dated signature must also be present, along with procedure code, diagnosis, location and amount of service time (face-to-face and total time). (Go to www.acbhcs.org/providers for progress note templates; QA Manual Policy on Documentation Standards, and the Mini-Insyst Manual.)

Listed below are the specific requirements for progress notes by program type:

- **Outpatient Mental Health Services:** All notes must indicate procedure, diagnosis, location, date, and amount of time; and must include the treating clinician's signature, title, and the date. Group service notes must include the total count of ALL clients served (whether Medi-Cal or not); service time is the addition of group time plus the documentation time for ALL clients in the group (whether Medi-Cal or not).

Rehabilitative Day Treatment/Residential: Weekly Summary, including each day of service must be signed by the writer.

- **Intensive Day Treatment/Crisis Residential:** Daily Progress Notes must be signed and dated by the writer (LVN/RN, PT, MHRS, or a licensed, waived or registered LPHA). Weekly Summary must be signed by the writer with co-sign/date by a licensed, waived or registered LPHA.

Medication Progress Notes: Written by the program's psychiatrist and, at minimum, addresses medical necessity for services, signs and symptoms, efficacy/compliance/ adverse effects of prescribed psychotropic medications, lab results and planned interventions. A legible, dated signature must also be present, along with the procedure code, diagnosis, location, amount of face-to-face time, and total time. More information regarding documentation requirements are located in the "BHCS Psychotropic Medication Practice Guidelines", available from the BHCS Office of the Medical Director and in the BHCS Documentation Standards, located on the Provider Website. (www.acbhcs.org/providers)

While the treating psychiatrist determines the frequency of medication support visits, the "Guidelines" call for face-to-face visits at a minimum of 3-month intervals.

Legibility & Signatures¹¹: All writing must be legible and in ink. Signatures must include professional disciplines and, where noted, be dated. If licensed, a staff person must sign with their license designation.

Forms Required for the CQRT Meeting

CQRT Request Form: Each chart brought to the CQRT must include a form called the CQRT Request Form. There are adult and children's versions of this form (see website).

CQRT Minutes: The program representative also brings a list of the charts brought for review, called the CQRT Minutes – this must be filled out PRIOR to the CQRT meeting.

(Both forms are on the BHCS provider website, and in the Appendix of this Manual.)

The CQRT Request Form is an official request for approval to authorize reimbursement for ongoing services. Approval decisions and CQRT feedback to programs will be noted on this form. Do not complete any information below the Clinical Supervisor's signature line; that area is reserved for the CQRT reviewer and Chairpersons. ***The form must be a double-sided document and must not contain any markings or hole-punches that obliterate information.***

The treating clinician usually completes this form and signs with their title or credentials on their signature line. The LPHA Clinical Supervisor signs on their signature line, with LPHA credential and date, **after** reviewing the chart and CQRT Request Form to ensure that all CQRT documentation standards are met. If the treating clinician is licensed, he/she signs both lines.

If the Supervisor checks "Yes" in the Recommended Approval box, he/she is certifying that the chart has been reviewed & found to be in compliance. If the "No" box is checked, the chart has been found to be out of compliance and may receive a provisional 1-month return by the CQRT Chair. However, it is expected that charts and forms would be returned to the clinician for correction prior to the CQRT meeting.

Most elements on the CQRT Request Form are self-explanatory, therefore only certain elements are described below:

1-Month Provisional Return: Check this box if the chart had been given a provisional 1-month authorization and is being returned for re-review. In this case, also attach the previous CQRT Request Form which notes the needed corrections. (Otherwise, CQRT Request Forms should be kept in the program's administrative file.)

Admission Date and Next Cycle: The admission date is usually the same as the episode opening date.

- If an existing provider changes their BHCS contract status, client episode opening dates are re-set to a date determined by the County. In these cases, please use the new EOD but note the original admission date as well.

"Next Cycle" indicates the period of time being requested for approval. Typically, the dates will be from the 1st of the following month to the end of the 3- or 6-month timeframe, per

program type (i.e., from 3/1/07 to 8/31/07). Remember that the approval period always stays the same for each chart, based on the episode opening month.

Program Type/Services: Indicate your program type and check all services being requested for approval.

Tentative Discharge Date & Aftercare Plan: Provide a month/year by which the client is expected to terminate services at your program. Indicate the clinical aftercare plan & referrals anticipated, given expected improvements in functioning by that time.

SECTION 3: THE CQRT PROCESS

CQRT Function & Staffing Requirements

The CQRT is comprised of one of the following:

- BHCS administrative staff and qualified representatives of providers required to either attend a BHCS-operated CQRT or submit CQRT reviews to BHCS; or
- Qualified staff of contracted providers performing an internal review of their clinical records; or
- Qualified staff of several contracted provider programs that have agreed to review each others' clinical records (all participating providers must be contracted with Alameda County in order to preserve the privacy protection afforded to business partners of the County ...or per HIPAA regulations?)

Clinical records that meet documentation standards will receive a provisional authorization for the next period of mental health services. A chart with documentation deficiencies may be given a provisional 1-month authorization in which to address deficiencies and be re-reviewed the next month. All authorizations are considered "provisional" depending on such factors as a client's ongoing eligibility for services or a program's compliance with their contract.

The CQRT procedure is a required review of client charts. For providers identified on page 1, the CQRT procedure is required in order to receive ongoing authorization of Medi-Cal services. The review focus is on chart documentation that supports medical & service necessity for ongoing treatment with that provider. The CQRT procedure is in accordance with the California Department of Mental Health and the MHP policies and standards, and with policies established by the BHCS QA Office.

There are several BHCS CQRT meetings which meet a minimum of one time per month. The meetings are organized by type of program, primary treatment mode and/or populations served. Programs are assigned to their CQRT meeting by the MHP. If you are uncertain which meeting your program should attend, please contact the BHCS QA Office.

The CQRT consists of Chairpersons (BHCS supervisors/staff) and qualified representatives appointed by programs to bring their charts for review. Representatives must be trained in the CQRT procedures by their program **prior** to participation. Programs are strongly encouraged to designate a consistent person(s) to regularly attend the CQRT and report findings to the program. Reviewers do not review their own program's charts.

Once at the meeting, a representative has two roles – to address questions raised about their program's charts by other reviewer, and to act as reviewers of other program charts. Reviewers may identify documentation issues, make recommendations for corrective action and give positive feedback. The CQRT Chairs provide final approval for ongoing services.

Criteria for CQRT Agency Representatives:

- Must be program supervisors/or their designees, trained in the CQRT process, authorized to represent/provide feedback to their program.
- Must be licensed, waived, or registered LPHA's (Licensed Practitioner of the Healing Arts) staff (see the Glossary of Terms in this Manual).
- **Must know their County staff identification number.**
- Must be prepared to stay until ALL charts have been reviewed.
- Must provide 1 qualified representative for every 7 charts brought (i.e., 8-14 charts = 2 reps.; 15-21 charts = 3 reps.). Any exception to this ratio requires advance approval from the CQRT Chairperson.

The CQRT Meeting

In order for the BHCS CQRT meetings to operate efficiently, please follow these guidelines:

- Arrive at least 5 minutes before the start time. Representatives who bring charts more than 15 minutes late will not have charts reviewed at that meeting. They will need to contact the QA Office to arrange chart review by a different CQRT meeting that month, if possible. If not possible, the representative's tardiness may result in costly unauthorized services.
- Bring the required CQRT forms already completed: 1) CQRT Request Form for each chart; 2) the CQRT Minutes (list of charts for review).
- Sign the Attendance Sheet and place program charts in the designated area.
- Show the CQRT Minutes to the Chairpersons who keep a total count of charts to be reviewed. The Minutes also serve as a log of approval decisions per chart and must be completed during the meeting by the representatives.

Fifteen percent (15%) of the total number of charts receive an in-depth review, called a Quality Review. This Quality Review uses the reverse side of the CQRT Request Form which lists questions regarding basic chart documentation standards. All Quality Review charts should be reviewed first. The other 85% of charts receive a limited review, called a Clinical Review, which focuses on substantiating medical necessity and confirming the information on the front of the CQRT Request Form. Both the Clinical and Quality Reviews are explained in more detail below.

If a chart is being returned with corrections after a provisional 1-month authorization, it is reviewed only for those corrections. If the correction has been made but a new issue is noticed, that issue is only noted by the reviewer on the CQRT Request Form; full authorization is provided by the Chairperson.

HIPAA Note: All client-related material is confidential and must be handled appropriately per HIPAA guidelines. Please give any waste papers with identifying client data to the Chairs for shredding.

Chart Reviews: Clinical Review

The Clinical Review is a general review to establish medical and service necessity criteria. Reviewers first read the CQRT Request Form for basic substantiation of those criteria and to orient themselves to the client's treatment.

Reviewers also evaluate the following documentation:

- Discharge plan noted on the CQRT Request Form & reasons for continued treatment; ensure that the required signatures are on the Form.
- Client/Treatment Plan and Progress Notes for further substantiation of the criteria and timeliness of completion (per that chart's cycle). An emphasis is placed on the relationship between the Plan's objectives and Progress Note documentation, (should describe current symptoms/behaviors that reflect the primary diagnoses for treatment; should refer to specific objectives).
- Overall client progress toward Client Plan objectives, given the type and level of services provided.

Reviewers doing a Clinical Review sign the CQRT Request Form on the "CQRT Reviewer" signature line (below the program's Clinical Supervisor's signature line).

Chart Reviews: Quality Review

A Quality Review is a more comprehensive review of the chart. In addition to the elements of a Clinical Review described above, reviewers utilize the back of the CQRT Request Form (the Regulatory Compliance Checklist) to review the chart for all Checklist items, including proof of client notification of informing materials.

Reviewers doing a Quality Review sign the CQRT Request Form in the "Quality Review" signature box located in the bottom right corner of the form. They must provide their County designated staff number. A record is kept of all charts which received a Quality Review.

Chart Reviews: General Procedures

Each CQRT meeting may differ slightly in the way charts are reviewed, depending on the group and Chairperson. However, the following is a general guideline:

Whether a Clinical or Quality Review, as concerns or deficiencies are found, it is suggested that they be noted on a separate sheet while review continues. When the review is as complete as possible, consult about those issues with that chart's program representative. Very often, representatives can answer questions and find documents or information that resolves the issue. If the representative cannot help, then bring the chart to the Chair for consultation.

Complete the CQRT Request Form after reviewing each chart:

- Sign the form in the appropriate section;
- Indicate the status of documentation standards by checking the "Yes" or "Needs Discussion" box;
- Check one or more of the appropriate boxes in the Rationale for Continuation of Services section; and
- Provide comments to the program in the Committee Comments section. Note any positive aspects of the chart, state concerns or deficiencies and give constructive feedback. Committee comments should always indicate the specific chart deficiency if a 1-month authorization is recommended.
- Do not complete the back of the CQRT Request Form unless you are doing a Quality Review.

The Chairs review the Committee Comments section and give **Provisional Authorizations** for the requested timeframes if medical and service necessity criteria are met. (Remember, authorizations are always considered "provisional".)

The Chairs complete the lower left authorization/signature box. The authorization **Start Date** entered by the Chairperson will be the beginning of the next approval period (or the date of that CQRT meeting, if the chart was submitted out of its review cycle: *Chairpersons may only backdate an approval with the permission of the QA Office*). The authorization **End Date** will be the end of that chart's approval cycle, unless a 1-month authorization is given.

Copies of the completed forms are made for the program representatives to take back for their program's files. Original forms are maintained in QA Office files. The Chair also maintains a list of charts receiving a provisional 1-month authorization with the main reason for return indicated. Programs receive feedback via the QA Office if a significant number of charts in a 6-month period are given a 1-month authorization.

Section 4: Special Situations

Multiple Providers & Multiple Reporting Units

Multiple Provider Agencies Serving One Client

The MHP accepts that in some situations, a client may receive services by more than one program because their needs cannot be met by one provider. Some examples may include:

- A client receiving monthly medication support services provided by a psychiatric clinic while also receiving weekly individual or family treatment from an outpatient services provider.
- A client in an Intensive Day Treatment program while also receiving wraparound case management services as a result of out-of-home placement.

It is the MHP policy that duplication of mental health services is to be avoided. If multiple service providers are treating a client, the mental health charts at each provider site must document evidence of treatment collaboration, clear explanations of which provider is providing which service, and demonstrate that medical and service necessity for all services are met.

If other Alameda County agencies (i.e. Child & Family Services or Probation) are involved in the development of treatment goals for the client, this should be clearly documented in the chart as it impacts the mental health treatment. If you have any questions regarding this policy, please contact the Child & Youth Services Director, Alameda County Behavioral Health Care Services.

Multiple Reporting Units of One Provider

At times, clients receive services from multiple Reporting Units (RU's) of a single provider program; this does impact the CQRT and Client Plan cycles. The options below may be used by providers, depending on the specific circumstances.

When the services are started simultaneously, or within the same month of admission, a provider agency has two options regarding Client Plans:

1. Multiple Client Plans – one for each program's RU; or
2. Single Client Plan -- completed by the RU program with the earliest episode opening & which includes treatment objectives for each additional RU.

If a single Client Plan is used by more than one RU and the service that established the Initial Client Plan is discontinued, the remaining program RU's must complete a Client Plan to cover the current approval period. As above, the provider has the following options:

- i) Complete a single Revised Client Plan, noting the change in services; or
- ii) Change to multiple Revised Client Plans – one for each remaining program RU, noting the change in services and charting.

When the different RU services are not opened in the same month:

Providers must receive approval to authorize services based on the episode opening dates of **each** RU – therefore, each RU program will have its own CQRT Review and Client Plan cycles.

Some provider agencies create a separate client chart for each program RU, with copies of documents required to be in each chart (identifying which chart contains the originals). Other providers create a single, combined chart with clearly identified sections for each program RU so that CQRT reviewers can easily locate the documentation to be reviewed in any given cycle.

Glossary of Terms

ACBHCS: Alameda County Behavioral Health Care Services.

Authorization: Approval action provided by County-designated staff that allows for a provider agency to bill for mental health services provided to eligible clients; provided in 1-, 3- or 6-month intervals.

CDMH: California Department of Mental Health.

Clinical Review: Brief review of client chart documentation. See pg. 19 of this manual.

CQRT: Clinical Quality Review Team; Committee that reviews provider agency's client charts for Medical & Service Necessity criteria and authorizes reimbursement for services provided.

CQRT Request Form: Official request for approval to request reimbursement of mental health services provided by a contracted provider program; cover sheet for each chart brought to the CQRT for review; reverse side contains Regulatory Compliance checklist for chart documentation. See completed sample/blank form in the Appendix of the manual; see also Pgs.15 & 20 for how to fill out this form.

CQRT Minutes: Form filled out by provider agency staff listing all client charts brought to the CQRT for review; form is completed with each chart's approval decision during the CQRT meeting. See completed sample/blank form in the Appendix of this manual; see also Pg.15.

Episode Opening Date (EOD): Date of the first billable service for a client; sets the CQRT Review & Treatment Plan Cycles.

FSP: Full Service Partnership programs funded by the Mental Health Services Act (MHSA).

HIPAA: Health Information Portability & Protection Act; Federal law regulating documentation practices to protect client confidentiality.

LPHA: Licensed Practitioner of the Healing Arts; licensed clinical staff (MD, PhD, MFT, LCSW) and staff who are registered with the California Board of Behavioral Sciences, usually registered MFT/ASW interns; psychologists who are waived by the State to provide services; and Master's level clinical nurse specialists who have national or state licensed to practice independently. See the BHCS QA Manual, Sections 4 & 17 for more information.

MAA: Medi-Cal Administrative Activities which are recorded on the MAA form and do not include mental health services provided directly to program clients.

Medical Necessity: Chart documentation that establishes the necessity for mental health services provision given certain included diagnoses and supporting information. See the reverse side of the CQRT Review Form, as well as the "Medical Necessity for Specialty

Mental Health Services” found in Title 9, Chapter 11, Sect. 1830.205(b)(1)(A-R) available at the DMH website.

MHP: Mental Health Plan; the Medi-Cal insurance plan for mental health services.

MHSA: Mental Health Services Act.

Program Representative: Clinical Supervisor or designee of a provider program who brings client charts to the CQRT for review & acts as CQRT Reviewers at the meeting.

Program: An ACHBCS contracted provider of Specialty Mental Health Services.

QA Office: Quality Assurance Office of the ACBHCS.

Quality Review: Comprehensive review of client chart documentation; follows Regulatory Compliance checklist on reverse side of CQRT Request Form. See pg. 19 of this manual.

Review Cycles: Cycle of months in which a client’s chart must be reviewed by the CQRT; based upon the month of the client’s episode opening date; always stays the same regardless of approval timeframes. See Section 1 of this manual.

RU/Reporting Unit: County-assigned number for a provider’s program(s); used for billing & charting purposes.

Service Necessity: Chart documentation that establishes the necessity for the level and quantity of mental health services being provided. See the reverse side of CQRT Request Form, as well as the “Medical Necessity for Specialty Mental Health Services” found in Title 9, Chapter 11, Sect. 1830.205(b)(1)(A-R) available at the DMH website.

Staff Number: County-assigned identification number for staff that provide services and chart documentation. Providers use a form to request staff numbers; it is posted on the BHCS provider website.

TBS: Therapeutic Behavioral Services; County-contracted individuals who provide supportive services to eligible mental health clients.

Client/Treatment Plan Cycle: Cycle of months in which a client’s Client Plans must be completed; based upon the month of the client’s episode opening date. See Section 1 of this manual.

Source Citations

(Materials are available on the Department of Mental Health website: www.dmh.ca.gov)

¹ California Code of Regulations (CCR), Title 9, Chapter 11 and Title 22, Section 51184.

² CCR, Title 9, Chapter 11, Section 1830.215 and Section J(4e) Non-Hospital Chart Review-EPSTD Reviews FY06-07.

³ CCR, Title 9, Chapter 11, Section 1810.204; Section J Non-Hospital Chart Review-EPSTD.

⁴ CCR, Title 9, Chapter 11, Section 1830.205(b), Section 1830.210(a); Section J Non-hospital Chart Review-EPSTD; DMH Letter No. 99-03, pages 6-7.

⁵ DMH Letter 02-01.

⁶ DMH Review Protocol, FY06-05, page 50, item 1c(5).

⁷ DMH Letter 02-01.

⁸ CCR, Title 9, Chapter 3, Section 532.4.

⁹ DMH Review Protocol, FY 06-05, page 55, item 3e.

¹⁰ Section I Non-Hospital Chart Review-EPSTD Reviews in FY06-07.

¹¹ CCR, Title 22, Chapter 7.2, Section 75343.