ALAMEDA COUNTY
BEHAVIORAL HEALTH CARE SERVICES

CQRT MANUAL

2007

CLINICAL QUALITY REVIEW TEAM

FOR

ADULT & CHILDREN'S SERVICES

Manual for Clinical Quality Review Team (CQRT)
Adult & Children's Mental Health Services
Alameda County BHCS
2007

Table of Contents

The CQRT Manual, meeting schedules and form templates are available on the Alameda County BHCS website (www.acbhcs.org/providers under Quality Assurance).

CQRT Overview

The Clinical Quality Review Team (CQRT) is composed of Behavioral Health Care Services (BHCS) staff and representatives of provider programs contracting with Alameda County to provide Specialty Mental Health Services[1]. There are several CQRT committees which meet on a monthly basis to review the medical records (charts) brought by program representatives. The purpose of the CQRT meeting is to provide a mechanism to review chart documentation so that programs can enter claims for Medi-Cal reimbursement of ongoing specialty mental health services.

The CQRT focuses on paperwork that supports medical necessity[2] & service necessity[3] (i.e., Treatment Plans, Progress Notes, etc.) for ongoing services, and on consent forms required to be present in all charts. Please refer to the BHCS Quality Assurance Manual, Section 8 for a complete description of the documentation standards, as the CQRT Manual provides only major highlights. Supporting regulations are referenced and cited on page 28 in the Appendix of this Manual, Source Citations.

The only programs which require CQRT approval to authorize services are Intensive Day Treatment programs for adults and children. Newly contracted programs of any type are required to attend the CQRT for one year; thereafter, programs establish their own method of chart review.

Charts meeting documentation standards will receive provisional authorization for the next period of mental health services. If a chart contains documentation deficiencies, a provisional 1-month authorization may be given and that chart would be returned to the next month's CQRT for re-review. 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.

If you have questions that are not addressed in this Manual, program staff should first consult with their Clinical Supervisor or the program's quality assurance staff. If your program does not have someone responsible for quality assurance issues, please consider appointing one or two staff as point-person(s) for receiving and disseminating CQRT information.

All provider programs have copies of BHCS policy/procedure manuals such as the Quality Assurance and Insyst Manuals, which can answer most questions related to charting. The BHCS website (www.acbhcs.org/providers) is also very informative and contains many downloadable documents. Other valuable resources are the California Department of Mental Health website (www.dmh.cahwnet.gov), and the California Institute of Mental Health (www.cimh.org) which posts the 2007 EPSDT Documentation Manual and powerpoint presentation.

If questions remain unanswered, program QA staff may email Jane Tzudiker in the BHCS QA office (jtzudiker@acbhcs.org).

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

Initial Review & Approval

Program staff must complete an Initial Assessment and Initial Treatment Plan within 30 days of a client's episode opening date (EOD or admission date). The only exception to this is for MHSA Full Service Partnership (FSP) programs, which must complete an interim problem/goal statement within 30 days of the EOD, and an Initial Treatment Plan within 60 days of the EOD. The initial period of approval for reimbursement of services occurs when the program's licensed Clinical Supervisor reviews and approves the Initial Treatment Plan by signing that document. Designated program staff may then enter an authorization into the PSP system (see Insyst Manual).

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 for the first 6 months by the program's licensed Clinical Supervisor & every 6 months thereafter.

- Rehabilitative Day Treatment: *CQRT provides initial approval at the first CQRT meeting after the expiration of the 30-day treatment plan approval date,* then 6 months from the opening episode date & every 6 months thereafter.

- Intensive Day Treatment: prior Placement Authorization is required (see BHCS provider's website for more information). Initial approval for the first 3 months by the program's Clinical Supervisor & every 3 months thereafter. Note: Though these charts are reviewed every 3 months, treatment plans are completed every 6 months.

- MHSA FSP: authorization by Crisis is required prior to 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 Day Treatment programs should keep in mind their 3-month designation.

Chart Review Cycle

As just noted, the months in which a specific chart must be reviewed depends on the 1) 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". Though potentially confusing, it is essential to understand how to determine review cycles for proper approval of ongoing services.

It can be very helpful to look at the following annual calendar while reading examples of chart cycles. A more detailed description begins on page 5.

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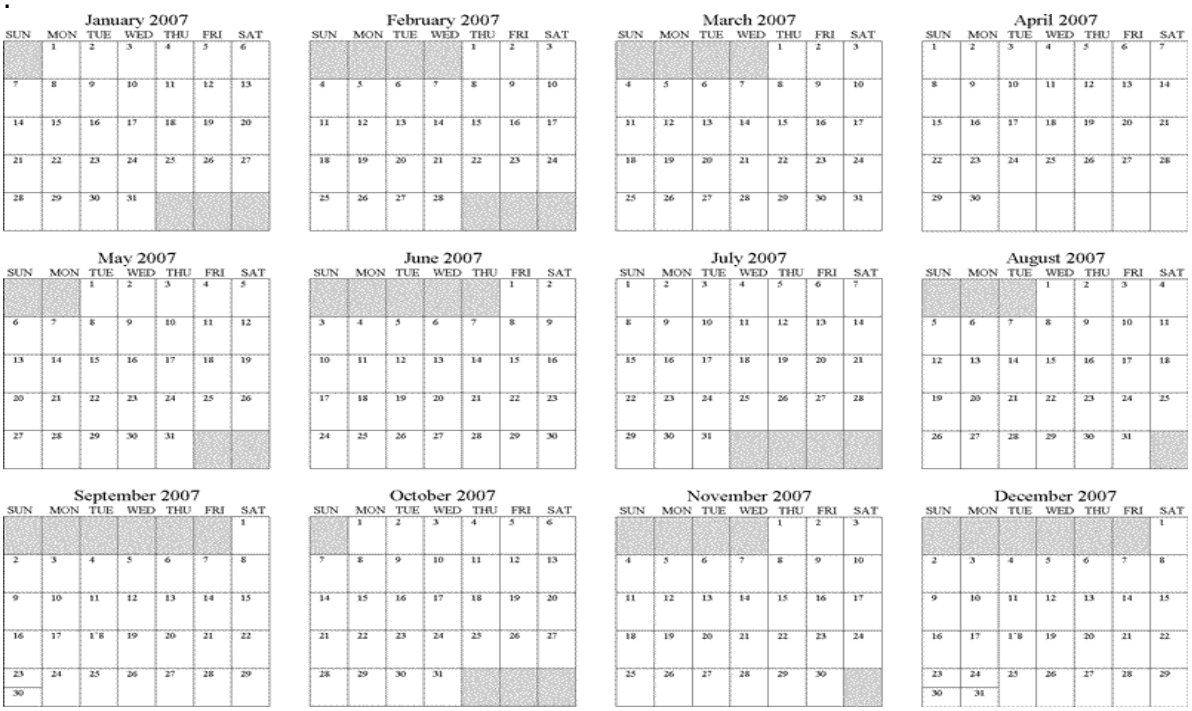


Example of Outpatient & Rehabilitative Day Treatment chart review cycle
August EOD: First "review cycle" starts August 1st & goes through the end of the 6th month, or January 31 of the next year. This chart is first reviewed by CQRT in January & each subsequent 6 months (July, January…), so that authorization can be provided starting the 1st of the following months. This chart's CQRT review cycle will <u>always</u> be July/January for authorization beginning August 1st & February 1st.

Example of Intensive Day Treatment chart review cycle (every 3 months)
August EOD: first "review cycle" starts August 1st & goes through the end of the 3rd month, or October 31. Program provides this initial review & authorization. This chart is first reviewed by CQRT in October & each subsequent 3 months (Jan., April, July, Oct., Jan…), so that authorization can be provided starting the 1st of the following months. This chart's CQRT review cycle will <u>always</u> be October/January/April/July, for authorizations starting November 1st/February 1st/May 1st/August 1st.

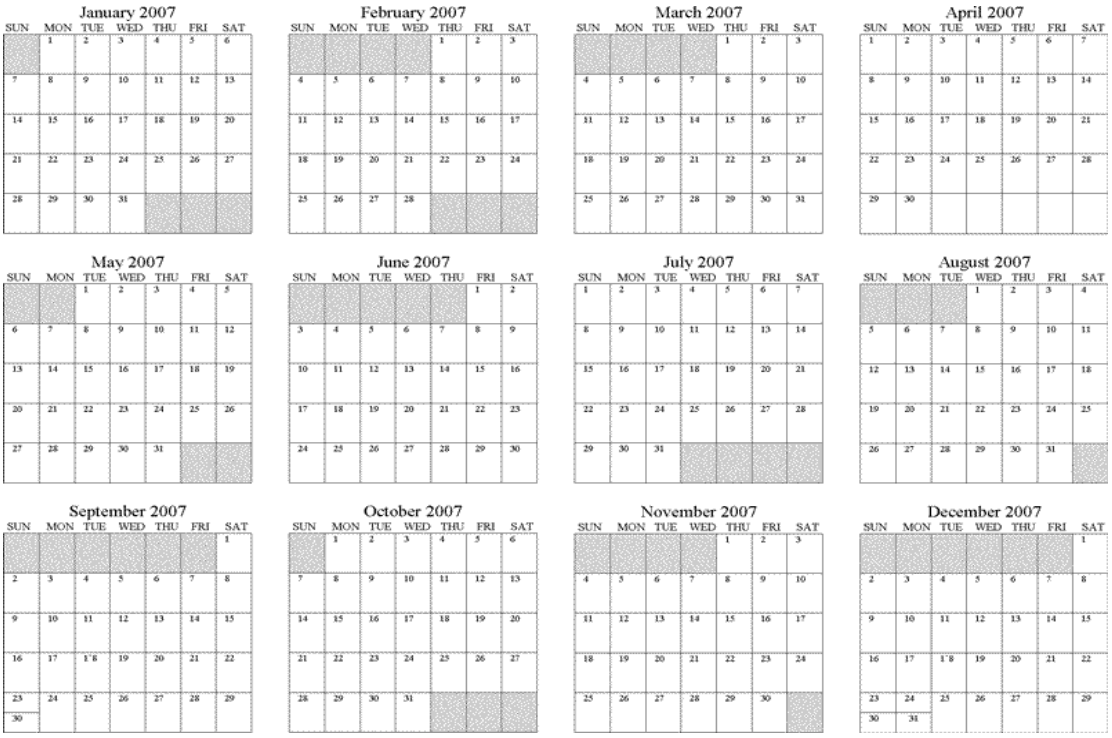
You can see that charts must be reviewed by the CQRT during the month **before** the next review cycle begins, so that services for the following period can be authorized. If a chart is brought to the CQRT later than its scheduled review, there is a risk of not getting authorization for the interim services.

The review cycle for each chart always stays the same, regardless of the approval period. This is very important. 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 begins on the first day of the month in which the episode was opened – and it always stays the same for that chart.

Treatment Plan Cycles

The timing of when treatment plans are done must be relative to the CQRT review cycle. This is because the CQRT must have a recently completed treatment plan in order to determine medical and service necessity. Again, it is helpful to view an annual calendar while reading an example.



Example: An Outpatient client's EOD is 10/28/06. That means the Initial Assessment and Initial Treatment Plan are completed just prior to 11/28/06. (Page 6 explains when treatment plans are considered "final".)

The next treatment plan to be done is a 6-month revision, or a Treatment Plan Update.

Though the Initial Treatment Plan is done in November, the Treatment Plan Update is completed 6 months after the October EOD of 10/28/06, **not** 6 months after November's Initial Treatment Plan. So the Treatment Plan Update must be completed just prior to 3/28/07.

The next plan will be a new Annual Treatment Plan, done 6 months later, just prior to 9/28/07, and every year thereafter just prior to the anniversary of the client's EOD.

The treatment plan sequence looks like this: Initial Treatment Plan, Treatment Plan Update, Annual Treatment Plan, Treatment Plan Update, etc.

As the example on Page 5 notes, you must use the episode opening date to determine each treatment 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, so it has to be in the chart and already approved by a Licensed Practitioner of the Healing Arts (LPHA)[4] when brought to the CQRT meeting.

Sometimes, when already-contracted providers change their status, some client EOD's are re-set to a date determined by the County. In this situation, a new treatment plan cycle must be initiated to coordinate with the new EOD.

Date of LPHA Signature

In that same example, treatment plans are written and finalized "just prior to" a certain date. There are regulations for **when** a treatment plan can be signed by an LPHA to consider the plan finalized: A treatment plan may be developed and written prior to its due date, but the LPHA signature must be dated no more than 15 days before the end of the current CQRT review cycle (sometime between mid- to late month).

To determine the signature date timeframe, count backwards 15 days from the last day of any month. The timeframe will usually be from the 15th or 16th of the month until the CQRT meeting date. But in February (short month) and in months when the CQRT meets earlier, the timeframe can be small and may allow only a few days for the LPHA to sign the treatment plan. Pages 8 & 9 of this Manual give examples of annual review & treatment plan timetables by month & the corresponding signature timeframes.

Treatment Plan Addendums

A Treatment Plan Addendums should 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 Treatment Plan and Update must still be done according to that chart's CQRT review cycle.

For example, an Outpatient Services chart with a January/July review cycle needs an updated Treatment Plan in June due to a significant change in the primary focus of treatment. The Annual Treatment Plan was just done in January, the Addendum is done in June, but a Treatment Plan Update will still need to be done in July to stay on cycle.

The next page shows an example of one chart's CQRT review cycle, along with its treatment plan cycle, to demonstrate how the episode opening date affects both processes. The subsequent two pages show annual timetables by month of episode opening for different program types.

Example of a CQRT Review Cycle & its Treatment Plan Cycle

Client's episode opening date: August 29

Initial Review by Program
Initial Treatment Plan completed within 30 days
of the episode opening date; signed by LPHA by: September 29

Services approved for the 1st approval period: ***August 1 – January 31***

1st CQRT Review
Treatment Plan Update completed,
signed by LPHA between: January 16 & CQRT date

Chart brought for CQRT review: Late January CQRT date

Services now approved for 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 Ongoing CQRT Review
new Annual Treatment Plan completed,
signed by LPHA between: July 16 & CQRT date

Chart brought for CQRT for review: Late July CQRT date

Services now approved for the 3rd period: ***August 1 – January 31***

Outpatient & Rehabilitative Day Treatment:
CQRT Review/Treatment Plan Cycles

EPISODE OPENING MONTH	APPROVAL PERIODS	CQRT REVIEW CYCLE	TX PLAN CREATED FOR:	TX PLAN NOT SIGNED BEFORE:
January	Jan. 1 - June 30 July 1 - Dec. 31	June December	July 1st January 1st	June 15th Dec. 16th
February	Feb. 1 - July 31 Aug.1 - Jan. 31	July January	August 1st February 1st	July 16th Jan. 16th
March	Mar. 1 - Aug. 31 Sept. 1 - Feb. 28	August February	Sept. 1st March 1st	Aug. 16th Feb. 14th
April	April 1 - Sept. 30 Oct. 1 - Mar. 31	September March	October 1st April 1st	Sept. 15th March 16th
May	May 1 - Oct. 31 Nov. 1 -Apr. 30	October April	November 1st May 1st	Oct. 16th April 15th
June	June 1- Nov. 30 Dec. 1- May 31	November May	December 1st June 1st	Nov. 15th May 16th
July	July 1 - Dec. 31 Jan. 1 - June 30	December June	January 1st July 1st	Dec. 16th June 15th
August	Aug. 1 - Jan. 31 Feb. 1 - July 31	January July	February 1st August 1st	Jan. 16th July 16th
September	Sept. 1 - Feb.28 Mar. 1 - Aug.31	February August	March 1st September 1st	Feb. 14th Aug. 16th
October	Oct. 1 - Mar. 31 Apr. 1 - Sept. 30	March September	April 1st October 1st	March 16th Sept. 15th
November	Nov. 1 - Apr. 30 May 1 - Oct. 31	April October	May 1st November 1st	April 15th Oct. 16th
December	Dec. 1 - May 31 June 1 - Nov. 30	May November	June 1st December 1st	May 16th Nov. 15th

Intensive Day Treatment: CQRT Review/Treatment Plan Cycles

EPISODE OPENING MONTH	APPROVAL PERIODS	CQRT REVIEW CYCLE	Tx PLAN CREATED FOR:	Tx PLAN NOT SIGNED BEFORE:
January	Jan. 1 – March 31 April 1 - June 30 July 1 – Sept. 30 Oct. 1 - Dec 31	March June September December	July 1st January 1st	June 15th Dec. 16th
February	Feb. 1 – April 30 May 1 – July 31 Aug. 1 – Oct. 31 Nov. 1 – Jan. 31	April July October January	August 1st February 1st	July 16th Jan. 16th
March	March 1 – May 31 June 1 – Aug. 31 Sept. 1 – Nov. 30 Dec. 1 – Feb 28/29	May August November February	September 1st March 1st	Aug. 16th Feb. 14th
April	April 1 – June 30 July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31	June September December March	October 1st April 1st	Sept. 15th March 16th
May	May 1 – July 31 Aug. 1 – Oct. 31 Nov. 1 – Jan. 31 Feb. 1 - April 30	July October January April	November 1st May 1st	Oct. 16th April 15th
June	June 1 – Aug. 31 Sept. 1 - Nov. 30 Dec. 1 – Feb 28/29 March 1 – May 31	August November February May	December 1st June 1st	Nov. 15th May 16th
July	July 1 - Sept. 30 Oct. 1 – Dec. 31 Jan. 1 - March 31 April 1 – June 30	September December March June	January 1st July 1st	Dec. 16th June 15th
August	Aug. 1 - Oct. 31 Nov. 1 - Jan. 31 Feb. 1 - April 30 May 1 - July 31	October January April July	February 1st August 1st	Jan. 16th July 16th
September	Sept. 1 - Nov. 30 Dec. 1 - Feb 28/29 March 1 - May 31 June 1 - Aug. 31	November February May August	March 1st September 1st	Feb. 14th Aug. 16th
October	Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30 July 1 – Sept. 30	December March June September	April 1st October 1st	March 16th Sept. 15th
November	Nov. 1 – Jan. 31 Feb. 1 – April 30 May 1 – July 31 Aug. 1 – Oct. 31	January April July October	May 1st November 1st	April 15th Oct. 16th
December	Dec. 1 – Feb 28/29 March 1 – May 31 June 1 – Aug. 31 Sept. 1 – Nov. 30	February May August November	June 1st December 1st	May 16th Nov. 15th

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 on the BHCS provider's website). 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, the BHCS QA Manual, Section 8 Documentation Standards, and to the CIMH EPSDT Documentation Manual.

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 same elements as the templates. County-operated clinics, however, 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 Assessment[5] (completed within 30 days of episode opening date)
- Annual Community Functioning Evaluation (within 30 days of episode opening date & annually thereafter)
- HIPAA Privacy Notice (with evidence of re-issuance every 3 years starting 2006)
- Freedom of Choice
- Beneficiary Problem Resolution form (with evidence of annual re-issue)
- Consents for Release of Information, 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 treatment plan; if that history is unavailable to the clinician, indicate this and any plan to obtain it. Also indicate factors that impair normal development, for example, trauma, illness or environmental/family stressors.

Client Treatment Plans:
All charts must contain Client Treatment Plans[6] that are based on the program's Assessment. The dated LPHA signature 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 treatment plans.

Initial/Annual Treatment Plan: Only selected plan elements are described below, as most are self-explanatory on the current template of this form on the BHCS provider's

website. (A sample is in the Appendix of this manual; please check the site regularly for updated versions).

- DSM (current edition) Diagnosis[7]: 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 licensed clinician who determined the diagnoses, and the date they 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 QA Manual, Section 13).

- Impairment Criteria and Service Necessity[8]: Provide a narrative which documents the signs and symptoms to support Axis I and Axis II diagnoses, as described by the DSM (current edition). The narrative should support impairment criteria via description(s) of 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
  - Probability of significant deterioration in important area(s) of life functioning
  - Probability that a child will not progress developmentally as individually appropriate **AND** that the mental disorder can be corrected or ameliorated

  This narrative section 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 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). If a client is stable but there is a need for specific services to address language, ethnic, cultural or accessibility needs that are not available elsewhere, provide justification of why a primary care physician or therapist in private practice cannot adequately provide these services.

- 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 treatment plan objectives that address them. Data in this section should be consistent with descriptions of current areas of risk documented elsewhere on the treatment plan/chart. If there are no identified risks, note "N/A" to indicate that an assessment was done.

- Client Strengths & Resources: Describe these and 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 Initial/Annual Treatment 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 on BHCS provider's website), instead of the usual Treatment 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 cognitive behavioral individual therapy 1x/week".

  If a client receives services from more than one program, indicate which program staff provides each service (and document in progress notes any collaborative efforts to meet the client's needs). 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 should be indicated on the Treatment Plan and 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 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 treatment plan objectives.

- Objectives[9]: 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 treatment plan.

  > For example: "Area of Need: Client bolts from the classroom when unable to tolerate increased anxiety. Objective: Within 6 months, CF will ask teacher for permission to take 2-minute break from classroom in 3/5 instances of escalating anxiety; CF 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 Treatment Plan[10]: Demonstrated by the client and/or parent/guardian signatures on the Treatment 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 "*a minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services" (CA Family Code 6924).*

- Signed & Dated by LPHA[11]: The treating Clinician who wrote the Plan must provide a dated signature; if not an LPHA, the dated co-signature of the licensed Clinical Supervisor (LPHA) is also required. Refer to Page 5 of this Manual for timeframes of the LPHA signature. If medications are prescribed by the provider agency, the prescribing Psychiatrist must also sign the Treatment Plan.

Treatment 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 provider website template of the Treatment Plan includes a section at the end for the Update (same signature rules apply).

Treatment Plan Addendum: An Addendum to any Treatment Plan should be written whenever there is a significant change in treatment focus or situation. It may just be a handwritten signed/dated paragraph to a current Plan. (Regardless of when an Addendum is done, an Update or Annual Treatment Plan must still be done, per the treatment plan cycle.)

Progress Notes

Each progress note[12] should indicate what has been done to assist the client toward the objectives identified in their Treatment 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, location and amount of face-to-face time. (See the BHCS provider's website for progress note templates; see the QA Manual, CIMH EPSDT Chart Documentation Manual & the Mini-Insyst Manual for more information.)

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

- Outpatient Mental Health Services: All notes must indicate procedure, location, date and amount of time, and include the treating clinician's signature, date and title.

- Rehabilitative Day Treatment/Residential: Weekly Summary, including each day of service, must be signed by the writer with co-sign/date by an LVN/RN, PT, MHRS or registered LPHA.

- Intensive Day Treatment/Crisis Residential: Daily Progress Notes must be signed and dated by the writer (LVN/RN, PT, MHRS or a registered LPHA). Weekly Summary must be signed by the writer with co-sign/date by an 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 procedure code, location and amount of face-to-face time. More information regarding documentation requirements are located in the "BHCS Psychotropic Medication Practice Guidelines", available from the BHCS Office of the Medical Director. 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 & Signatures[13]: All writing must be legible and in black ink. Signatures must include professional disciplines and, where noted, be dated. If licensed, a staffperson must sign with their license designation. Electronic signatures may be used for progress notes, but not for Treatment Plans.

Forms Required for the CQRT Meeting

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. 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. Sometimes, when already-contracted providers change their 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 procedure is a required review of client charts to receive approval to authorize Medi-Cal reimbursement of ongoing mental health services. Review focus is on chart documentation that supports medical & service necessity for ongoing treatment with that provider. The 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 CQRT meetings which meet a minimum of one time per month, towards the end of each 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 charts by other reviewers & 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 LPHA's (Licensed Practitioner of the Healing Arts). Please see the Glossary of Terms in this Manual and refer to the BHCS QA Manual, Section 4.
- Must know their County staff identification number (provided by their program).
- Must be prepared to stay until ALL charts have been reviewed.
- Must provide 1 qualified representative for every 10 charts brought (i.e., 11-20 charts = 2 reps.; 21-30 charts = 3 reps.). Any exception to this ratio requires advance approval from the CQRT Chairperson.

The CQRT Meeting

In order for the 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 the information on the front of the CQRT Request Form. Both the Clinical and Quality Reviews will be 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 usually 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.
- 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 Treatment 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 and includes all elements of a Clinical Review.

In addition, reviewers utilize the back of the CQRT Request Form (the Regulatory Compliance Checklist) to review the chart for all Checklist items, including the following completed forms:

- Annual Community Functioning Evaluation
- HIPAA Privacy Notice
- Freedom of Choice documentation and
- Beneficiary Problem Resolution form.

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, first consult about those issues with that chart's program representative. Very often, representatives can answer questions and find documents/information that quickly 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 is 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 Treatment 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 Treatment Plans:

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

   If a single treatment plan is used by more than RU and the service that established the Initial Treatment Plan is discontinued, the remaining program

RU's must complete a Treatment Plan to cover the current approval period. As above, the provider has the following options:

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

When the different RU services are <u>not</u> 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 Treatment 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.

Sample Progress Notes

Four most common reasons for disallowed progress notes:

- **Missing notes**
- **Does not address mental health condition**
- **Note is solely clerical**
- **No client contact/participation**

(Acceptable) Collateral 7/20/06 311 Phone 25 mins. 30 (total)
Returned call to caregiver. Talked to mother regarding a recent incident at the school for which client was suspended. She is very concerned about his behavior and the impact on the younger children in the home. Discussed safety issues in the home and reminded her of interventions practiced in sessions to help de-escalate client's aggressive behavior. Plan: Will meet at our regular time next week.
-Juan Perez, MFT

(Disallowed – No client contact) Collateral 7/20/06 311 Phone 25 mins. 30 (total)
Returned call to caregiver who had left urgent message to contact her regarding client's behavior last night. Tried several times but phone was busy. Then caregiver's boyfriend answered phone; left message with him to let caregiver know writer had tried to call many times. Plan: Will await caregiver's return call.
-Juan Perez, MFT

(Acceptable) Assessment 6/15/06 331 Office 70 mins. 90 (total)
Met with client and caregiver for first appointment. Caregiver is monolingual Hmong speaking, writer is bi-lingual. Client is a 13-year-old Hmong male who was referred due to truancy and aggressive behavior at school. He is also failing several courses. Father is deceased. Client denies any gang affiliation but mother is still concerned about his peers. Explained how services will be provided, problem resolution, confidentiality, etc. Plan: Continue to assess and develop a plan with the client and mom.
-Mai Vang, MFT

(Acceptable) Individual Therapy 6/22/06 341 Office 50 mins. 65 (total)
Met with client for individual session. Discussed progress toward treatment goals. She is still concerned about her reactions in social settings but states that she is less depressed and anxious and may start taking a dance class after school. Client shared journal entries relating to abuse she suffered three years ago. Explored feelings and thoughts triggered by those memories. Role-played coping skills to contain anxiety about peer pressure at school. Encouraged client to continue practicing coping skills and praised her for continuing to use her feelings journal.
-Carmen Miranda, MFT

(Disallowed – Solely clerical) Individual Therapy 6/22/06 341 Office 20 mins. 65 (total)
Goal: client will increase sleeping from 2-3 hours a night to 6-8 hours. Impairment: symptoms of adjustment d/o with mixed anxiety and depressed reportedly interfere with client's functioning ability at home, school & community. Intervention: received t/c from client's mother regarding client's scheduled therapy session for today. Mother told writer she & client can't make it to appointment due to has another appointment for client's doctors to check his diabetes. Mother requested to reschedule. This writer was able to coordinate another time to meet w/ family.
-Carmen Miranda, MFT

(Acceptable) Group Therapy Session 8/13/06 351 Office Co-staff Jason Thomas, LCSW (2 staff, 60 min. group, 10 clients)
This writer co-facilitated a mixed gender social skills group emphasizing peer relationships. Client participated in today's group activity which involved role playing with peers in various social situations. She stated that she enjoyed the activity and stated that it actually helped to alleviate some of her anxiety in dealing with social situations. Writer and the co-facilitator split the group into male and female and role played several examples within the groups and then brought them back together for discussion and more role playing.
-Jim Randolph, MFT

(Disallowed – Nothing about specific client) Group Therapy Session 8/13/06 351 Office Co-staff Jason Thomas, LCSW (2 staff, 60 min. group, 10 clients)
This writer co-facilitated a mixed gender social skills group emphasizing peer relationships. All clients participated in the group activity which involved role playing with peers in various social situations. They stated they enjoyed the activity and that it was especially helpful to alleviate anxiety – each member shared what type of social situation made them most anxious. The group was then split into males & females for discussion about traditional vs. current gender roles and where they believe they fit in. The whole group then met & shared the main points of the smaller group discussions.
-Jim Randolph, MFT

(Acceptable) Individual Rehabilitation 4/29/06 381 Field 45 mins. (f-t-f) 70 (Total)
Worked with client on hygiene skills which are impacted by his depression and social isolation behaviors. He has not taken a shower this week. Created a chart with him to help keep track of his ADLs and his feelings so that he can see how they impact one another. He was willing to do this activity. Client was talkative and maintained eye contact during the session. He responded well to praise and seemed hopeful at the end of the session. Plan: Monitor progress with chart at the next session.
-Cindy Lu, MHAII

(Disallowed – No mental health intervention) Individual Rehabilitation 4/29/06 381 Field 45 mins. 70 (total)
Writer picked up client and took her to her podiatrist's office where she had an appointment. The client told me about her previous day's activities and how stressed out she'd been. Writer went into the doctor's office with the client and waited for the doctor to examine her foot, then returned the client to her B&C. Plan: Monitor client's health needs in next sessions.
-Cindy Lu, MHAII

(Acceptable) Plan Development 3/3/07 581 Office 70 mins. 120 (total)
Met with client and caregiver to develop a treatment plan that will help the client reduce aggressive, acting out behaviors, which include self harm and cruelty to animals. Discussed goals and objectives with them. Received input from both of them. Developed a safety plan with crisis numbers and alternative behaviors to practice when client begins to be agitated. Plan: to provide individual and family therapy weekly.
-Miriam Smith, LCSW

(Disallowed – Doesn't address mental health condition) Plan Development 3/3/07 581 Office 70 mins.
This writer researched studies on the internet which have been done on babies who were born with methamphetamines in their systems. Found website on study which started in 1999 in Hawaii with mothers & babies in this situation. The grant was also given to UCLA & Brown. At

this point, this writer left messages for researchers at UCLA & Brown to request a copy of the study to find out more information about "evidence based practice" interventions being used.
Plan: to provide this information to client in next session.
-Miriam Smith, LCSW

(Acceptable) Case Management 9/14/06 571 Phone 30 mins.
Spoke with CPS Social Worker regarding the foster parents concern with client's increasingly violent behaviors and their inability to keep her in their home since they also have three other foster children. CPS worker will discuss options with the foster family at her next visit. Worker asked that this writer continue to meet with the client weekly to monitor behaviors. Will continue to provide case management with client and include caregivers as appropriate.
-Amar Sarat, MHRS

(Disallowed – Doesn't address mental health condition) Case Management 9/14/06 571 Phone 30 mins.
Spoke with attorney representing client's father. Attorney said he & opposing counsel had a "hearing with the judge" and that Dr. XXX is bringing her files with her to court hearing. Writer reminded attorney that nothing has changed since her letter to him dated 7/2/06. Writer reminded attorney that the records sought are confidential and privileged and that the clinic cannot legally or ethically release such records unless the client's mother authorizes release of them or the clinic receives a court order. Attorney recommended writer contact mother's attorney to further discuss the issue.
Plan: contact mother's attorney.
-Amar Sarat, MHRS

(Acceptable) Crisis Intervention 12/17/06 371 Office 180 mins. 200 (total)
Mother phoned and client can be heard screaming profanity in the background. Mother is afraid for the safety of others in the home. Client is threatening bodily harm to mother and a younger sibling. Mother asked for help in dealing with this situation. Worker will go out to the home to intervene. Gave mom worker's mobile phone number. Recommended calling the police immediately or taking client to MERT for an evaluation if she feels safe in transporting the client. Client refused to speak to this writer.
-Yoshiko Sumi, MFT

(Disallowed – No imminent psychiatric risk to client) Crisis Intervention 12/17/06 371 Office 60 mins. 70 (total)
Mother brought client into office for an emergency appointment because she did not know how to respond to the client's request for information regarding her biological father. Mother was very distraught but the client was surprisingly calm and said "I was just asking a question; I don't know why she's so upset. I know my dad's in jail and has done some bad things." Worked with mother to calm down and recognize that it was her own feelings that had created the upset & that it would be a great topic to discuss in her own individual therapy. We then provided the information about her father to the client which was that he was born in Detroit and didn't have any siblings.
Plan: f/u with mother in next session re. if she spoke about this in her own therapy.

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 waivered 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.

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

STATE DEPARTMENT OF MENTAL HEALTH MEDI-CAL MEANAGED CARE

Medical Necessity for Specialty Mental Health Services That are the Responsibility of the Mental Health Plans

Must have all A, B, and C:

A. Diagnoses

Must have one of the following DSM Included diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- ☐ Pervasive Developmental Disorders, except Autistic Disorder which is excluded.
- ☐ Disruptive Behavior Attention Deficit and Disorders
- ☐ Feeding & Eating Disorders of Infancy and Early Childhood
- ☐ Elimination Disorders
- ☐ Other Disorders of Infancy, Childhood, or Adolescence
- ☐ Schizophrenia & Other Psychotic Disorders
- ☐ Mood Disorders
- ☐ Anxiety Disorders
- ☐ Somatoform Disorders
- ☐ Factitious Disorders
- ☐ Dissociative Disorders
- ☐ Paraphilias
- ☐ Gender Identity Disorders
- ☐ Eating Disorders
- ☐ Impulse-Control Disorders Not Elsewhere Classified
- ☐ Adjustment Disorders
- ☐ Personality Disorders, excluding Antisocial Personality Disorder
- ☐ Medication-Induced Movement Disorders

Excluded Diagnoses:

- ☐ Mental Retardation
- ☐ Learning Disorders
- ☐ Motor Skills Disorder
- ☐ Communication Disorders
- ☐ Autistic Disorder (Other Pervasive Developmental Disorders are included.)
- ☐ Tic Disorders
- ☐ Delirium, Dementia, Amnestic, and other Cognitive Disorders
- ☐ Mental Disorders due to a General Medical Condition
- ☐ Substance-Related Disorders
- ☐ Sexual Dysfunctions
- ☐ Sleep Disorders
- ☐ Antisocial Personality Disorder
- ☐ Other Conditions, including V-Codes, that may be a focus of Clinical Attention (Except medication included movement disorders which are included.)

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Impairment Criteria

Must have <u>at least one</u> of the following impairments as a result of the mental disorder indentified in the Identified Diagnoses list above:

1. A significant impairment in an important area of life functioning, or
2. A reasonable probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a reasonable probability the child will not progress developmentally as individually appropriate. [Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply.)]

C. Intervention Related Criteria

Must meet <u>each</u> of the criteria below:

1. The focus if proposed intervention is to address the condition identified in impairment criteria "B" above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children, it is probable the intervention will allow the child to progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated,) and
3. The condition would not be responsive to physical health care based treatment. [14]

EPSDT beneficiaries with an *Included Diagnoses* and a substance related disorder may receive Specialty Mental Health Services directed at the substance use component. The intervention must be consistent with and necessary to the attainment of the Specialty MH treatment goals.

Alameda County Behavioral Health Care Services
Mental Health Division

Confidential Administrative Records

Clinical/Quality Review Committee Meeting Minutes

Meeting Date: _____ Page __1_____ of ____1____

Provider Agency:_____

Cases Reviewed:

Name	**RU #**	**Case #/PSP #**	Clinical **Review**	Quality **Review**	30 Day **Return** **Check if yes**
1.		. . . . .	**A/R**	**A/R**	
2.		. . . . .	**A/R**	**A/R**	
3.		. . . . .	**A/R**	**A/R**	
4.		. . . . .	**A/R**	**A/R**	
5.		. . . . .	**A/R**	**A/R**	
6.		. . . . .	**A/R**	**A/R**	
7.		. . . . .	**A/R**	**A/R**	
8.		. . . . .	**A/R**	**A/R**	
9.		. . . . .	**A/R**	**A/R**	
10.		. . . . .	**A/R**	**A/R**	
11.		. . . . .	**A/R**	**A/R**	
12.		. . . . .	**A/R**	**A/R**	
13.		. . . . .	**A/R**	**A/R**	
14.		. . . . .	**A/R**	**A/R**	
15.		. . . . .	**A/R**	**A/R**	
16.		. . . . .	**A/R**	**A/R**	
17.		. . . . .	**A/R**	**A/R**	
18.		. . . . .	**A/R**	**A/R**	
19.		. . . . .	**A/R**	**A/R**	
20.		. . . . .	**A/R**	**A/R**	
21.		. . . . .	**A/R**	**A/R**	
22.		. . . . .	**A/R**	**A/R**	
23.		. . . . .	**A/R**	**A/R**	
24.		. . . . .	**A/R**	**A/R**	
25.		. . . . .	**A/R**	**A/R**	
26.		. . . . .	**A/R**	**A/R**	
27.		. . . . .	**A/R**	**A/R**	
28.		. . . . .	**A/R**	**A/R**	
29.		. . . . .	**A/R**	**A/R**	
30.		. . . . .	**A/R**	**A/R**	

CHILDREN'S MENTAL HEALTH SERVICES
CLINICAL/QUALITY REVIEW

Date:

☐ **Returned after 30-day provisional authorization. ***
* Please attach the previous CQRT form to this one.

Client Name:
Client PSP# :
Provider Name: **Program:**
Reporting Unit:
Clinician:
Admission Date:
Next Cycle:
From: **To:**

Class:
☐ **Regular Education** ☐ **Independent Study**
☐ Resource Specialist Program ☐ Special Day Class
☐ Counseling Enriched Special Day Class
☐ NPS Day Treatment
☐ School-Based Day Treatment

Handicapping Condition(s):
☐ Emotionally Disturbed
☐ Specific Learning Disability
☐ Learning Handicapped
☐ Other Handicapping condition: _____

AB3632: ☐ **Yes** ☐ **No**

Request for:

OUTPATIENT MENTAL HEALTH SERVICES (check all that apply)
☐ Individual/Family Treatment/Collateral
☐ Group Treatment
☐ Rehabilitation Services
☐ Case Management/Brokerage Services
☐ Medication Services

DAY TREATMENT SERVICES (check one)
☐ **INTENSIVE:** **90 Days (3 months)**
☐ **REHABILITATIVE:** **180 Days (6 months)**

Service Necessity (current or within past six months):

☐ Level 1. OR ☐ Level 3
☐ Psychiatric hospitalizations.
☐ Suicidal/homicidal ideation or acts.
☐ Psychotic symptoms.
☐ At risk for out of home placement or change in placement.
☐ Severe school and social impairment due to mental disorder.
☐ Other: _____

Symptoms and Behaviors Supporting Current Diagnosis and Service Level:

Current Level of Functioning and Response to Treatment Interventions:

Tentative Discharge Date and Aftercare Plan:

Clinician:	
Signature and Date	
Clinical Supervisor:	Recommended Approval: ☐ Yes ☐ Needs Discussion
Signature and Date	
CQRT Reviewer:	Recommended Approval: ☐ Yes ☐ Needs Discussion
Signature and Date	

Rationale for Continuation of Services:
☐ At risk for psychiatric hospitalizations.
☐ Suicidal/homicidal ideation or acts.
☐ Severe or psychotic symptoms.
☐ At risk for out of home placement or change in placement.
☐ Severe school and social impairment due to a mental disorder.
☐ Other (specify): _____

Committee Comments:

Provisional Authorization: ☐ Yes ☐ No	Quality Review: ☐ Approved ☐ Return to Supervisor *(See Back Page)*
Start Date: End Date:	
Committee Chair:	Reviewer:
Signature and Staff Number	Signature and Staff Number
Approval Date:	Review Date:

CQRT Children's Services 6-2004

QUALITY REVIEW Regulatory Compliance							
Medical Necessity:	**Yes**	**No**	**N/A**	**Treatment Plan:**	**Yes**	**No**	**N/A**
Five Axes DSM-IV included Diagnosis for Specialty Mental Health Services				1. Initial Treatment or Service Plan completed by 30 days of opening episode date.			
Impairment Criteria: ***Must have one of the following as a result of diagnosis:***				2. Treatment Plan reviewed every 6 months from opening episode date, updated or revised every 6 months and rewritten annually.			
1. A significant impairment in an important area of life functioning, or							
2. A probability of significant deterioration in an important area of life functioning, or				3. There is a revised Treatment or Service Plan when there was a significant change in plan, service, diagnosis, problem, or focus of treatment.			
3. A probability that the child will not progress developmentally as individually appropriate.							
4. Children covered under EPSDT qualify if they have a mental disorder, which can be corrected or ameliorated. (Current DHS EPSDT regulations apply.)				4. Treatment Plan includes objectives and planned interventions addressing identified impairments and strengths.			
Intervention Criteria: Must have 1, 2, and 3				5. Objectives are measurable.			
1. The focus of proposed intervention is to address the condition identified in the Impairment Criteria, and				6. Treatment Plan Review (TPR) or Service Plan (SP) is signed and dated by LPHA.			
2. It is expected the client will benefit from the proposed intervention by diminishing the impairment or preventing significant deterioration in an important area of life function, and/or				7. Treatment Plan Review signed and dated by MD, if the provider prescribes the medication.			
2A. It is probable the child will progress developmentally as individually appropriate, or				8. Treatment Plan Review signed and dated by client/family/guardian.			
2B If covered by EPSDT can be corrected or ameliorated, and				**Progress Notes:**			
				Progress Notes are related to the TPR/SP's goals and objectives.			
3. The condition would not be responsive to physical health care-based treatment.				**Mental Health Services:**			
				1. All Progress Notes are signed and dated with title.			
Service Necessity:				2. Procedure, location, date, and amount of time documented.			
1. What is the risk of the client's level of dysfunction increasing if fewer services were provided?				**Intensive Day Treatment/Crisis Residential:**			
Low 1 2 3 4 5 High				1. Daily Progress Notes are signed/co-signed and dated by LPHA or LVN, PT, or MHRS.			
2. Can a different type/level of Specialty Mental Health Services meet this client's need for services reasonably well?				2. Weekly summaries are signed/cosigned and dated by LPHA.			
3. Can a primary care physician or private practitioner/therapist meet this client's need for services (a lower level of care) reasonably well?				4. Placement Authorization is in chart for all Episodes opened after July 1, 2003.			
Evaluation and Consent:				**Rehabilitative Day Treatment/Residential:**			
1. Prenatal, perinatal and comprehensive developmental history is present.				1. Weekly summaries are signed/co-signed and dated by LPHA or LVN, PT or MHRS.			
2. Annual Community Functioning Evaluation or Youth Performance Outcome Measures are present.				2. Each date of service is identified in Progress Note.			
				3. Placement Authorization is in chart for all Episodes opened after July 1, 2003.			
				Special Needs:			
3. HIPAA Privacy Notice provided.				1. The client's cultural and linguistic needs are documented.			
4. Freedom of Choice is documented.				2. Information is provided to a client with visual and hearing impairments, if applicable.			
5. Beneficiary Problem Resolution form is present.				**Therapeutic Behavioral Services (TBS)**			
Legibility:				TBS services are documented in the TP, if applicable.			
Writing and signatures are legible.							

ALAMEDA COUNTY Behavioral Health Care Services

MENTAL HEALTH SERVICES
CLINICAL/QUALITY REVIEW

Date: _____

Client Name: _____
Client PSP#:
Provider Name:
Reporting Unit:
Clinician:
Admission Date:
Review Period: *from* *to*

Request for (check all that apply):

Mental Health Services:
- ☐ **Individual/Family Treatment/MHS**
- ☐ **Group Treatment/MHS**
- ☐ **Rehabilitation Services/MHS**
- ☐ **Case Management/Brokerage Services/MHS**
- ☐ **Medication Services/MHS**

Day Treatment Services (check all that apply):

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

REHABILITATIVE:
☐ **Initial** ☐ **180 Days (6 months)** ☐ **5 Days/Week or less**
☐ **Exceeds 5 Days/Week**

Service Necessity (current or within past six months):
- ☐ **Psychiatric hospitalizations**
- ☐ **Suicidal/homicidal ideation or acts**
- ☐ **Psychotic symptoms**

Tentative Discharge Date and Aftercare Plan:

Supporting Comments/Outcomes Desired with Continued Services:

Clinical Supervisor: _____ **Signature**
Recommended Approval: ☐ **Yes** ☐ **No** ☐ **Needs Discussion**

CRT Reviewer: _____ **Signature**
Recommended Approval: ☐ **Yes** ☐ **No** ☐ **Needs Discussion**

Rationale for Continuation of Services:
- ☐ **At risk for psychiatric hospitalizations:**
- ☐ **Suicidal/homicidal ideation or acts:**
- ☐ **Severe or psychotic symptoms:**
- ☐ **Other:**

Committee Comments:

Provisional Authorization: ☐ **Yes** ☐ **No**
Start Date: **End Date:**
Committee Chair:
Signature **Staff #**
Approval Date:

Quality Review: ☐ **Approved** ☐ **Return to Supervisor**
(See back page)
Reviewer:
Signature
Review Date:

CQRT Adult 2-04-2003

Medical Necessity:	Yes	No	N/A
1) Five Axes DSM-IV included diagnosis for Specialty Mental Health Services.			
2) Documentation supports diagnosis.			
3) A significant impairment in an important area of life functioning, or			
4) Probability of significant deterioration in an important area of life functioning.			
Intervention Criteria: Must have all, 1, 2, and 3			
1) The focus of proposed intervention is to address the condition identified above and			
2) Client is expected to benefit from the proposed intervention by diminishing the impairment or preventing significant deterioration in an important area of life functioning and/or			
3) The condition would not be responsive to physical healthcare based treatment alone.			
Service Necessity:			
1) Can a different type/level of Specialty Mental Health Services meet this client's need for services reasonably well?			
2) Can the client's needs be met through less frequent services?			
3) Can a primary care physician or private practitioner/therapist meet this client's need for services (lower level of care) reasonably well?			
4) Is the client benefiting or likely to benefit from the intended service?			
Evaluation and Consent:			
1) Annual Community Functioning Evaluation or Adult Performance Outcomes are present?			
2) Freedom of Choice is documented?			
3) HIPAA Privacy Notice Provided.			
4) Signed Consumer Grievance form is in chart (or Note of Signature Refusal/Incapacity) is present.			

Treatment Plan:	Yes	No	N/A
1) Treatment or Service Plan is completed by 30 days of opening?			
2) Treatment Plan is reviewed every 6 months from opening episode date, revised, and re-written annually.			
3) Treatment Plan is revised when a significant change occurs in service, problem, or focus.			
4) Clinical risks are noted and assessed.			
5) Client strengths are noted and assessed.			
6) Adequate plan established to contain any identified Clinical Risk.			
7) Treatment Plan includes measurable objectives and planned interventions that address identified impairment(s).			
8) Treatment Plan signed by client or notation made why client did not sign.			
9) Family participation and agreement with client plan is documented, if family is involved.			
10) Treatment Plan Review or Service Plan is signed and dated by LPHA.			
11) Treatment Plan is signed by MD if the provider prescribes the client's medications.			
Progress Notes:			
1) Progress Notes relate to the TPR/SP's goals, objectives, and interventions.			
2) All Progress Notes are signed with the practitioner's title.			
3) Procedure, location, date, and time are documented for each service.			
Special Needs:			
1) Client's cultural and linguistic needs are documented.			
2) Information provided to clients with visual and hearing impairments, if applicable.			
Legibility:			
1) Writing and signatures are legible.			

Reviewer:

Signature:

Results: ☐ **Meets Standards**
☐ **Corrections Needed**
> 10% Error Rate

Date:

Level I Adult Outpatient Services 2-04-2003

ALAMEDA COUNTY
Department of Behavioral Health Care Services
- Mental Health Services

DSM-IV Multiaxial Diagnostic Evaluation
Initial Assessment Summary/Treatment Plan

Client Name:
Birthdate: Admit Date:
Chart No: Reporting Unit:
PSP Client ID No:

Diagnosis

(Please complete all five Axes)

Axis I: Clinical Disorders

Other Conditions that may be a Focus of Clinical Attention

Diagnostic Code		DSM IV Name	
_____	_____		(Principal)
_____	_____		
_____	_____		
_____	_____		

Axis II: Personality Disorders
Mental Retardation

Diagnostic Code		DSM IV Name
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Axis III: General Medical Conditions

Axis IV: Psychological and Environmental Problems (Circle all that apply) Principal

- **A.** Problems with primary support group Specify: _____ ☐
- **B.** Problems related to the social environment Specify: _____ ☐
- **C.** Educational problems Specify: _____ ☐
- **D.** Occupational problems Specify: _____ ☐
- **E.** Housing problems Specify: _____ ☐
- **F.** Economic problems Specify: _____ ☐
- **G.** Problems with access to health care services Specify: _____ ☐
- **H.** Problems related to interaction with legal system/crime Specify: _____ ☐
- **I.** Other psychological and environmental problems Specify: _____ ☐
- **J.** Unknown/Unavailable ☐

Axis V: Global Assessment of Functioning Scale

Current Score: _____
Highest Past Year Score: _____

Diagnosis established by: _____ Date: _____
Name/Title/Agency

2. Signs and Symptoms That Support DSM IV Diagnosis: (List each diagnosis separately.)

3. Risk Assessment/Reduction Plan: (Check and list interventions.)

☐ Suicidal/Self Harm ☐ Health

☐ Violence ☐ Other(s):

4. Strengths and Resources: (Note client and family strengths and resources and plan to utilize.)

5. Family Goals Participation in Client Plan: (If none, note reason)

6. Special Needs: (Check all that apply. Describe and state plan to address these needs.)

☐ Cultural ☐ Linguistic ☐ Visual/Hearing ☐ Handicapping Condition

Plan:

7. Estimated Duration of Treatment:

8. Prognosis: ☐ Excellent ☐ Fair ☐ Poor

9. Medication Regimen: ☐ No Prescribed Medication ☐ See Medication Records

☐ Prescribed by Outside Medical Doctor (If box checked list medications with dosages and physician's name/telephone number)

10. Tentative Discharge Plan:

11. Professional Disciplines Responsible and Specific Treatment Interventions/Services/Frequency:

12. Client Goals:

Long term:

Short term:

ALAMEDA COUNTY **Department of Behavioral Health Care Services** **- Mental Health Services** **Treatment Plan**	Client Name: Birthdate: Admit Date: Chart No: Reporting Unit: PSP Client ID No:

Treatment Plan Instructions: Define problems, symptoms and functional impairments in measurable terms. Objectives must be <u>measurable with timeframes</u>. (Please address the following areas of need that apply: Health, Living Arrangements, Daily Activities, Social Relationships, and Symptom Management.)

Area of Need:

Problem No.: Statement:

Objective(s): Date Objectives Achieved:

Area of Need:

Problem No.: Statement:

Objective(s): Date Objectives Achieved:

Area of Need:

Problem No.: Statement:

Objective(s): Date Objectives Achieved:

Area of Need:	
Problem No.:	Statement:
Objective(s):	Date Objectives Achieved:
Area of Need:	
Problem No.:	Statement:
Objective(s):	Date Objectives Achieved:
Area of Need:	
Problem No.:	Statement:
Objective(s):	Date Objectives Achieved:
Area of Need:	
Problem No.:	Statement:
Objective(s):	Date Objectives Achieved:
Area of Need:	
Problem No.:	Statement:
Objective(s):	Date Objectives Achieved:

ALAMEDA COUNTY
Department of Behavioral Health Care Services
- Mental Health Services

Treatment Plan

Client Name:
Birthdate: Admit Date:
Chart No: Reporting Unit:
PSP Client ID No:

I understand that I may have a copy of my treatment plan:

Client Signature_____ Approval ☐ Yes ☐ No* Date: _____

Clinician Signature _____ ☐ LPHA/Waivered Date: _____

Supervisor Approval _____ ☐ N/A Date: _____

Psychiatrist Approval _____ ☐ N/A Date: _____

* If client does not approve plan, note reason(s):

Treatment plan changes:

Client Signature_____ ☐ Yes ☐ No* Date: _____

Clinician Signature _____ ☐ LPHA/Waivered Date: _____

Supervisor Approval _____ ☐ N/A Date: _____

Psychiatrist Approval _____ ☐ N/A Date: _____

* If client does not approve plan, note reason(s): ☐ Yes ☐ No Date

Client Name:	
Birthdate:	Admit Date:
Chart No:	Reporting Unit:
PSP Client ID No:	

Clinician's Service Necessity Rating (Please complete only at the indicated timeframe)

☐ 6 months ☐ 1 year ☐ 1.5 years ☐ _____

Please complete the Service Necessity Rating by considering whether the client needs this level of treatment and/or services from this program to maintain community functioning in the following areas:

A. Client is at risk of not having a permanent living arrangement, including being homeless or at risk of becoming homeless. (For children at risk of out of home placement.)	Low Service Need				High Service Needs
	1☐	2☐	3☐	4☐	5☐
B. Client has identified need for this level of care to prevent difficulties in education/employment/day/ social activities.	Low Service Need				High Service Needs
	1☐	2☐	3☐	4☐	5☐
C. Client will not have the ability to establish and maintain relationships including social support system.	Low Service Need				High Service Needs
	1☐	2☐	3☐	4☐	5☐
D. Client will be unable to maintain physical/mental hygiene including management of his/her medication. (Consider age appropriate.)	Low Service Need				High Service Needs
	1☐	2☐	3☐	4☐	5☐
E. Client will exhibit psychotic symptoms, or suicidal ideation/acts or violent ideations or acts to persons or property.	Low Service Need				High Service Needs
	1☐	2☐	3☐	4☐	5☐
F. There is a high risk of recurrence to a level of functional impairment.	Low Service Need				High Service Needs
	1☐	2☐	3☐	4☐	5☐

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 1810.205 & Section 1830.210.

[3] Ibid.

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

[5] CCR, Title 9, Chapter 11, Section 1810.204; Section J Non-Hospital Chart Review-EPSDT.

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

[7] DMH Letter 02-01.

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

[9] DMH Letter 02-01.

[10] CCR, Title 9, Chapter 3, Section 532.4.

[11] DMH Review Protocol, FY 06-05, page 55, item 3e.

[12] Section I Non-Hospital Chart Review-EPSDT Reviews in FY06-07.

[13]CCR, Title 22, Chapter 7.2, Section 75343.

[14] CCR, Title 9, Section 1830.205 & 1830.210