alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Clinical Quality Review Team (CQRT) Glossary for Outpatient Programs

CQRT Checklist Items	Glossary
1. Informing Materials page is signed/initialed and on time.	• The Informing Materials Acknowledge of Receipt form must be completed before or during the intake appointment and annually by the last day of the month prior to the client's opening month. • All boxes on the form must be checked • Signatures and dates are required at initial review and initials and date are required annually. • Resource: See Section 10: BHCS Providers Website (acbhcs.org)
2. Informed consent for medication(s) is present for each prescribed medication (when applicable) and includes signature of the person providing the service, their professional degree, licensure or job title, relevant identification number (e.g. NPI) and signature date. Also signed by beneficiary, and if not signed, reason why not.	• Informed consent for medication(s) must be signed for each prescribed medication initially and whenever changes to medications are made. • If the initial Medication Consent Form included a range for the daily dose or frequency, the form can be updated with the changes and dated and initialed by the client and provider, instead of completing and signing a new form. • The consent form must be signed and dated by the client. If the client consents to taking medications but declines to sign the form, this should be documented in the space available on the Consent Form or in an associated Progress Note, along with the reason client declined to sign • All sections on the form must be completed.
Assessment & Medical Necessity	**Assessment & Medical Necessity**
3. Required assessment is present and signed by staff with credentials to do so. If not present, reason for delay is noted.	• The Mental Health Assessment includes information on all CalAIM domains • The assessment is signed by a Registered, waivered, or licensed LPHA. • Includes require co-signatures based on scope of license. • Resource**:** CalMHSA Documentation Guides
4. The Client's physical limitations, cultural and communication needs, or lack thereof, are noted.	• Psychosocial factors noted on the assessment, or elsewhere in the chart, include information about the client's physical, cultural, and communication needs, or lack thereof.
5. Documentation of coordination of care is present, anywhere in the chart, as clinically appropriate.	• It is evident from the assessment and or progress notes that efforts are being made to coordinate care with other providers as clinically appropriate. • Examples include, but aren't limited to, the presence of Releases of Information authorizing communication with other service providers and/or documented efforts to communicate with other providers.
6. CANS/ANSA is finalized and signed on time (with all sections	• Childhood Assessment of Needs and Strengths (CANS) or Adult Needs and Strengths Assessment (ANSA) tools are completed by day 60 of Episode Opening, every 6 months, and at discharge.

completed) by staff with credentials to do so.	• These tools must be completed by Registered, Waivered or Licensed LPHA or an MHRS.
7. PSC35 is present or documentation of parent refusal/lack of response is in chart.	• The Pediatric Symptom Checklist (PSC35) must be completed by day 60 of Episode Opening, every 6 months and at discharge. • If not completed, there should be documentation of refusal or lack of response.

8. MH diagnosis or suspected diagnosis (includes Z codes) is present. If suspected or Z code is used, notes indicate efforts to clarify the diagnosis.	• A Mental Health Diagnosis is an important component of providing targeted, appropriate services.
	• Documentation in the medical record must initially demonstrate that the beneficiary meets the specific access criteria for each delivery system. If a diagnosis cannot be immediately established, specific Z Codes are allowed for billing and to start the Problem List.
	• Z codes are acceptable during the assessment period, if a diagnosis cannot be established immediately, or for beneficiaries under 21 years of age who are experiencing significant trauma placing them at risk of future mental health conditions. These include those involved in child welfare, juvenile justice or are homeless.
	• In above situations, the following options can be used:
	  ○ ICD-10 codes Z55-Z65 may be used by all providers, including an MHRS or other qualified staff and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
	  ○ ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP.
	  ○ In cases where services are provided due to a suspected disorder that has not yet been diagnosed, LPHA and LMHP may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."
	• If a Z code is used during the assessment phase, it should be clear why a diagnosis was not made and what efforts are being made to establish a diagnosis. For example, are medical records being requested from other providers, collateral sessions being scheduled with the family or school to gather more historical information, etc.
	• The established diagnosis is supported by the clinical notes.

9. Meets Access Criteria and/or Medical Necessity	• This is a Disallowance Reason • Documentation in the medical record must demonstrate that the beneficiary meets the specific access criteria for each delivery system. • Access Criteria (Persons Under 21 years of age): The person is experiencing significant trauma placing them at risk of future mental health conditions. These include those who are homeless, involved in child welfare or juvenile justice or those who scored in the high-risk

	range on a DHCS approved Trauma Screening tool (e.g. Pediatric ACES and Related Life-Events Screener (PEARLS) tool, ACE Questionnaire. • Access Criteria (Persons over 21 years of age): The person has significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in important area of life functioning, AND the significant impairments listed above are due to a diagnosed or suspected mental health disorder. • Medical Necessity (Persons age 21 and older): the service is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. • Medical Necessity (Persons under age 21 and older): the service is necessary to correct or ameliorate a mental illness or condition discovered by a screening service. These services can be delivered to sustain, support, improve or make more tolerable a mental health condition.
10. If risk occurred in the past 90 days, there is a comprehensive risk assessment and safety plan.	• Risk refers to danger to self, danger to others or any other behaviors that might create risk of harm to the client or others. • A comprehensive risk assessment and safety plan should be in the chart and reviewed with client.
11. The Standardized ACBH Screening Tool was completed prior to admission and transitions of care.	This item will be required once the Standardized Screening Tool is released by the State. Anticipated date: 1/1/2023. Until that time, use N/A
Problem List	**Problem List**
12. A Problem List is present and supported by the documentation in the chart.	• A Problem List should be started as soon as possible once the client is admitted • It should include all required components as noted in the CalMHSA Documentation manual. • End dates are added only when problems are resolved or deferred. • The Archive option is only used if a problem was added to the chart in error. • The problems on the list should be generally consistent with the chart notes and reflect the client's current issues.
Progress Notes (spot check 3-5)	**Progress Notes (spot check 3-5)**
13. The progress note was signed (or electronic equivalent) by the person(s) providing the service and the service provided was within the scope of practice of the person delivering the service.	• This is a DHCS Disallowance Reason • Resource: ACBH Scope of Practice grid • Progress Note is missing clinician signature. • This item can be removed from the CQRT Checklist or marked as N/A if the agency's Electronic Health Record automatically captures and ensures appropriate scope of practice for each service. The Electronic

	Health Record Attestation Form must be completed and provided to ACBH prior to removing this item from the checklist. Completed Attestation must be kept for your records and sent to ACBH, along with your CQRT Tracking Tool and/or completed CQRT Checklists when requested.
14. Progress Notes describe how interventions address beneficiary's mental health needs or Social Determinants of Health and planned action steps. If non-reimbursable services were provided, the note clarifies that the time was not claimed	• This is a DHCS Disallowance Reason • Non- reimbursable services include the following: ○ Academic educational service ○ Vocational service that has work or work training as its actual purpose. ○ Recreation ○ Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors. ○ Transportation ○ Clerical ○ Payee Related
15. Notes for services involving one or more providers, include: a) Total number of providers and their specific involvement in delivering the service, b) Time involved in delivering the service for each provider (includes travel and documentation); c) Total number of beneficiaries participating in the service.	This is a DHCS Disallowance Reason
16. For Case Management services, there is a Care Plan present in a Progress Note.	• Per CalMHSA Documentation Manual, the Care Plan must be in narrative form and include the following required elements: ○ Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the person in care; ○ Includes activities such as ensuring the active participation of the person in care, and working with the person (or the person's authorized health care decision maker) and others to develop those goals; ○ Identifies a course of action to respond to the assessed needs of the person in care; and ○ Includes development of a transition plan when the person in care has achieved the goals of the care plan.