Alameda County Behavioral Health Care Services (ACBHCS)

CQRT Manual

Developed by the Quality Assurance Office

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Section I: Clinical Quality Review Team (CQRT) Overview:

This manual describes the ACBHCS CQRT and Authorization process for Outpatient Specialty Mental Health services. The manual describes the policy, procedure, and expectations of all county and contracted organizational providers that participate in either ACBHCS-operated CQRT, or a provider's internally run CQRT in accordance with contractual obligations.

ACBHCS Quality Assurance (QA) Office CQRT Participation:

ACBHCS licensed Clinical QA staff provide monthly (or more if needed) trainings and oversight of the CQRT and Authorization process for certain providers and agencies. Newly contracted organizational providers and agencies new to Specialty Mental Health Services (SMHS) claiming are required to attend ACBHCS operated CQRT meetings for a period of time designated by the MHP. *(It is common for new agencies to attend ACBHCS operated CQRT for 1 year or longer and regular feedback to providers will be given.)*

Organizational providers with previous CQRT experience in Alameda County are also required to participate in ACBHCS operated CQRT if they develop new programs or when a Community Based Organization (CBO) that has never claimed to SMHS Medi-Cal begins to provide and claim for SMHS Medi-Cal.

The following circumstances require contracted organizational providers to attend ACBHCS CQRT within the first 3 months of the beginning of their contract:

- A new agency
- A new program for an existing agency
- A program that is new to Medi-Cal claiming
- Existing programs changing from a Fee-for-Service contract to contracted CBO

Additionally, providers with Plans of Corrections (POC), or providers that fail to (or inadequately) conduct internal CQRT may be required to return to the ACBHCS operated CQRT meetings to receive additional trainings and oversight for a period of time designated by the MHP.

Transitioning from Attending County Operated CQRT to Agency Run ("Internal") CQRT.

The goals of the monthly 3-hour County-operated CQRT sessions are to provide oversight, authorization, and clinical feedback in regard to agency's chart documentation quality. A Provider must demonstrate consistent competency in the CQRT process and have their Internal CQRT Policy & Procedure approved by the QA office in order to be permitted to transition out of the county run process and continue this monthly process independently. Consistent competency includes but is not limited to, demonstrating an ability to be constructively critical of one's own organization's provision and documentation of services, legally and ethically address non-compliant issues, address issues of client safety in a timely manner, demonstrate honesty, trustworthiness, and transparency with BHCS CQRT, and back out non-compliant claims that cannot be acceptably redressed. It is not expected that charts reviewed at CQRT will be without problems or deficiencies. It is expected that programs be able to identify problems or deficiencies and respond accordingly.

Agencies and providers that have attended ACBHCS operated CQRT and have demonstrated

competency in coordinating/managing CQRT meetings, reviewing charts, and appropriately authorizing, will be released from the ACBHCS operated CQRT meeting and will be allowed to run internal CQRT meetings and to authorize cases reviewed at CQRT for specialty mental health services.

Requirements for Agencies Conducting Internal CQRT.

Each agency that has been released from ACBHCS operated CQRT meetings is expected to continue to conduct CQRT Internally and to appropriately authorize cases for specialty mental health services. The ACBHCS-operated Clinical Quality Review Team (CQRT) meeting is designed to model a process for providers and if replicated, will help providers review charts and authorize appropriately.

Providers are allowed to change certain elements of how they conduct CQRT. The following are a few examples of changes that agencies have made that still allow them to conduct CQRT and authorize appropriately.

- Instead of 1 meeting per month to review charts, agencies hold multiple meetings.
- Agencies partner with other agencies and run CQRT together. Each agency reviews the other agencies charts and this helps reduce any problems associated with reviewing charts within one's own agency.
- Admin staff (rather than CQRT chair) can help pull and get charts ready for review. They may also review certain non-clinical chart requirements (Example: that a client's allergies are listed on the front cover of a physical chart). See regulatory compliance sheet for a list of items that Admin staff may review.
- Student Trainees may be used to review charts if their licensed clinical supervisor has attested that the trainee has the training and experience to diagnose. Close supervision of trainees that are reviewing charts as part of CQRT is required and a licensed CQRT chair will always be responsible for approving and authorizing the chart and assuming responsibility that the chart was reviewed properly. In this regard, agencies can turn the CQRT process into an extensive training opportunity for staff.

Providers should never remove or alter items on the Medi-Cal Regulatory Compliance Tool without written approval from ACBHCS QA department. Doing so could cause critical elements to be lost or not reviewed which could lead to disallowances and a requirement that the agency return to ACBHCS operated CQRT meetings.
Providers may add additional items they feel are appropriate and want staff to review during CQRT.
Providers may incorporate forms into their Electronic Health Records system to help streamline the process. If Electronic Health records have limitations and changes to forms must be made to accommodate those limitations, ACBHCS QA department should be consulted to make sure the changes will not cause problems.

Agencies that obtain authorization through ACBHCS.

Per DMH Information Notice 02-06[1], contracted organizations that provide the following services are required to obtain payment authorization through ACBHCS:

- Day Rehabilitation (DR)
- Day Treatment Intensive (DTI)

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

- Outpatient SMHS delivered concurrently to Day Rehabilitation or Day Treatment Intensive (requires supplemental authorization – Please contact the ACBHCS Utilization Management Department)
- Therapeutic Behavioral Services (TBS)

These programs/services, in addition to obtaining payment authorization through ACBHCS, are expected to conduct a CQRT chart review to assure documentation compliance. Obtaining authorization through ACBHCS does not release programs from the requirement of conducting initial and annual CQRT chart documentation reviews.

Section II: Authorization of SMHS Medi-Cal:

The initial period of authorization of services begins with the opening of a client's episode in the INSYST system. The date of this episode opening is referred to as the Episode Opening Date (EOD). The initial period of service authorization depends on the type of provider program and the provider contract (*see below*). Unless otherwise specified in the provider contract, the completed Initial Assessment determines whether there is medical necessity for ongoing services and is due no later than 60 days from the EOD.

Once it is determined that a client does not meet medical necessity for specialty mental health services, no additional claims can be made to Medi-Cal and the case should be closed once ethical obligations for proper discharge have been met.

If a provider has difficulty establishing medical necessity by 60 days of the EOD due to a client's clinical presentation or extenuating circumstances, additional non-planned services (Assessment, Plan development, Targeted Case management {linkage and referral for stabilization purposes} Medication services {for the purpose of stabilization and ongoing medical needs} and crisis therapy may be provided while the clinician continues to gather information for the client's assessment and determination of medical necessity. No planned services may ever be provided until a client's assessment (which includes medical necessity) and treatment plan are completed.

If medical necessity is documented and the agency plans to provide additional services then the client's episode remains open. The length of the approval period depends on the type of provider program. Charts are authorized as follows:

Outpatient Mental Health Services:

- While an agency is participating in County operated CQRT, the CQRT chair will authorize the chart for the first year and annually thereafter.
- Once the MHP approves an agency to self-authorize, approval is completed by the provider program for the first year and annually thereafter.
    - When treatment plans are updated to include additional service modalities, frequency of services, or additional durations of services, additional authorization should also be obtained. An authorization form should be completed and a licensed clinician who is designated by the agency to review charts for medical necessity for these additional services should review the authorization form and approve the additional services (if appropriate) by signing the form. Charts seeking additional authorizations do not need a complete clinical or quality review and additional approvals do not need to be entered into INSYST at this time.

Adult Day Treatment—Rehabilitative & Intensive:

The following types of programs are required to seek authorization through ACBHCS Authorization Office.

- **For all programs that are 5 days or less per week:**
  - Programs more than 6 Months in Duration:
    Initial authorization must be requested no later than 60 days from the EOD. The initial authorization will start on the date the episode was opened and will run through the last day of the 6th month from the episode opening month. (e.g., start date 8/8/17; the CQRT Request Form must be faxed to the Authorizations Office by 10/7/17; authorized 8/8/14 to 1/31/18. The next authorization will run from 2/1/17 – 7/31/18. The CQRT form must be faxed to the Authorization office prior to 7/31/18.)
  - Time-limited Programs 3 – 6 Months in Duration (90 – 179 days): Initial authorization must be requested no later than 30 days from the EOD. The authorization will cover 3 months from the first day of the month that the episode was opened (e.g., start date 8/8/17; the CQRT Request Form must be faxed to the Authorization Office by 9/7/17; authorized 8/9/17 to 10/31/17.)
  - Time-limited Programs under 3 Months in Duration (45 – 89 days): Initial authorization must be requested no later than the seventh 7th day from the EOD. The authorization will cover 30 days from the episode opening date (e.g., start date 8/8/17; the CQRT Request Form must be faxed to the Authorization Office by 8/15/17; authorized 8/9/17 to 9/7/17.) The authorization at 30 days will authorize for 60 days, e.g. fax by 9/7/17; authorized from 9/8/17 to 11/6/17.
    Note: *For programs under 3 months, Assessments are due by the 7th day from EOD and Treatment Plans are due by the 15th day from EOD.*
- **For all programs that are 6 days or 7 days per week, contact ACBHCS Authorization department.**

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.

Review Cycle:

As previously noted, the months in which a specific chart must be reviewed depends on the type of provider program and the month of the client's EOD. This timing of chart review is referred to as the chart's "CQRT Review Cycle."

Client Assessment & Treatment Plan Cycles

Authorizing charts through the CQRT process is only possible when there is a recently completed Client Assessment and Treatment Plan for the pending authorization period. The reviewer must have access to these completed documents in order to determine ongoing medical necessity. The required Assessment and Treatment Plan must correspond with the CQRT review cycle.

The chart should be reviewed in the CQRT meeting before the next approval period begins. If charts are

reviewed after the approval period begins, claims may be at risk for disallowance if requirements are not met. When charts are reviewed for authorization prior to the approval period, depending on the issue, there may be time to address issues before any claims for the next authorization period have been made. Note that, if episodes are closed and then re-opened, the Assessment/Treatment Plan cycles must coordinate with the new EOD. The cycle and due dates described in this manual are the standard contracted dates, specific RUs may have contractually specified accelerated dates. Documentation must follow the dates specified in the contract.

Programs that obtain Authorization through ACBHCS must also have charts go through a CQRT documentation regulatory compliance review.

- Some programs require Authorization before the first day of service can be provided or soon after. Completing a CQRT documentation regulatory compliance review prior to authorization in these cases is not possible. Programs that have this occur should develop a policy and procedure for conducting CQRT documentation regulatory compliance review as close to the authorization date as possible to help reduce disallowances.

Assessment Dates and Signatures

Assessments are required to be written and finalized, prior to or on their due date. Initial assessments, in most SMHS cases, unless specified by the contract, are due within 60 days of the EOD. Annual assessments are due in the month prior to the episode opening month. Annual Assessments may be developed and written in an ongoing fashion but should be completed and finalized in the month prior to its due date. The date that the Assessment is finalized is determined by the signature and date of the staff, and any required co-signatures, completing the assessment. Refer to the ACBHCS Guidelines For Scope of Practice for a full description of staff that are allowed by Medi-Cal to complete a SMHS Assessment. Providers may require initial Assessments be due earlier than required due dates, but not later. Annual assessments may be developed with clients over time but must be finalized in the month prior to its due date.

Treatment Plan Dates and Signatures:

Treatment Plans, like assessments, are required to be completed prior to their due date which is determined by the client's EOD. Unless specified in the contract, Treatment Plans are due within 60 calendar days from the EOD. For client plans, the date it is effective is determined by the signature and date of the staff, and any required co-signatures. Clients are required to sign treatment plans unless the client's medical record specifically indicates what clinical barriers are preventing this from occurring and what future attempts will be made to obtain a signature. Verbal consent should always be documented when obtained as well. If a client signs a treatment plan past its due date, the treatment plan will still be considered valid and active based on the date that the clinician and any required co-signatures were obtained. It is the expectation that unsigned or plans signed late by a client will be uncommon and circumstances well documented when they do occur.

Because a client's treatment plan is not considered consent for treatment, but is designed to be a collaborative roadmap for treatment, clients under the age of 18 should sign their own plans when developmentally appropriate (which is determined by a clinician). Having both the client and their parents sign the treatment plan is best practice as it indicates all invested parties participated in the document, however only the client's signature is required. Like the Assessment, the annual Treatment Plan may be developed with a client over time but must be finalized in the month prior to its due date.

Changes in Client Mental Status, Diagnosis, Mental Health Objectives, Services Modalities, and/or Treatment Focus:

Adding additional information to Assessments may be accomplished by completing an Assessment Addendum (rather than rewriting an assessment). Treatment Plan changes require the plan to be re-written and signed. Examples include: whenever there is a significant change in the client's mental status, diagnosis, mental health objectives, service modality, and/or treatment focus, etc. This updated treatment plan supersedes the previous plan and must contain all active goals and objectives. When addendums to the Assessment and/or the Treatment Plan updates are implemented, complete signatures are required (unless exceptions are met). The Treatment Plan must be signed and dated by required parties to be considered valid.

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

When treatment plans are updated to include adding additional service modalities, increasing the frequency of services, or increasing the duration of services, these additional services must receive an authorization. In these instances, an authorization form should be completed and a licensed clinician who is designated by the agency to review charts for medical necessity for these additional services should review the authorization form and approve the additional services (if appropriate) by signing the form. Charts seeking additional authorizations do not need a complete clinical or quality regulatory compliance review and additional approvals do not need to be entered into INSYST at this time.

The following pages display timetables for the CQRT review cycles/authorization periods along with the Assessment & Treatment Plan cycles to demonstrate how the EOD affects both processes. Outpatient CQRT Review Cycle, Assessment, & Treatment Plan Cycle

Episode Opening Date	Due for Initial CQRT/ Authorization (For Outpatient Sx.) 60 Day Hard Count	Authorization (Cycle) Period	Annual CQRT Review Month	Annual Assessment & Treatment Plan Created	Client Plan Created For:
January (e.g. 1/15)	March 16	Jan. 1 - Dec. 31	December	December	January
February (e.g. 2/2)	April 3	Feb. 1 - Jan. 31	January	January	February
March (e.g. 3/30)	May 29	Mar. 1 - Feb. 28	February	February	March
April (e.g. 4/21)	June 20	April 1 - Mar. 31	March	March	April
May (e.g. 5/14)	July 13	May 1 - Apr. 30	April	April	May
June (e.g. 6/20)	August 19	June 1 - May 31	May	May	June

July (e.g. 7/9)	September 7	July 1 - June 30	June	June	July
August (e.g. 8/13)	October 12	Aug. 1 - July 31	July	July	August
September (e.g. 9/1)	October 31	Sept. 1 – Aug. 31	August	August	September
October (e.g. 10/17)	December 16	Oct. 1 - Sept. 30	September	September	October
November (e.g. 11/23)	January 22	Nov. 1 - Oct. 31	October	October	November
December (e.g. 12/7)	February 5	Dec. 1 – Nov. 30	November	November	December

Day Rehabilitation: CQRT Review Cycle, Assessment, & Treatment Plan Cycles

Episode Opening Month	Day Rehabilitation require assessments and treatment plans on First day	Authorization Periods	CQRT Review Months	Annual Assessments & Treatment Plans Created & Signed:	Client Plans Created For:
January (e.g. 1/15)		Jan. 1 - June 30 July 1 - Dec. 31	June December	June Dec.	July 1st January 1st
February (e.g. 2/2)		Feb. 1 - July 31 Aug.1 - Jan. 31	July January	July Jan.	August 1st February 1st
March (e.g. 3/30)		Mar. 1 - Aug. 31 Sept. 1 - Feb. 28	August February	Aug. Feb.	Sept. 1st March 1st
April (e.g. 4/21)		April 1 - Sept. 30 Oct. 1 - Mar. 31	September March	Sept. March	October 1st April 1st
May (e.g. 5/14)		May 1 - Oct. 31 Nov. 1 -Apr. 30	October April	Oct. April	Nov. 1st May 1st
June (e.g. 6/20)		June 1- Nov. 30 Dec. 1- May 31	November May	Nov. May	Dec. 1st June 1st
July (e.g. 7/9)		July 1 - Dec. 31 Jan. 1 - June 30	December June	Dec. June	January 1st July 1st
August (e.g. 8/13)		Aug. 1 - Jan. 31 Feb. 1 - July 31	January July	Jan. July	February 1st August 1st
September (e.g. 9/1)		Sept. 1 - Feb.28 Mar. 1 - Aug.31	February August	Feb. Aug.	March 1st Sept. 1st
October (e.g. 10/17)		Oct. 1 - Mar. 31 Apr. 1 - Sept. 30	March September	March Sept.	April 1st October 1st
November (e.g. 11/23)		Nov. 1 - Apr. 30 May 1 - Oct. 31	April October	April Oct.	May 1st Nov. 1st
December (e.g. 12/7)		Dec. 1 - May 31 June 1 - Nov. 30	May November	May Nov.	June 1st Dec. 1st

Section III: Chart Documentation & Preparing for the CQRT:

(Forms can be found on the Provider Website and are updated regularly. Please check for updates and attend county offered trainings regarding updates).

Forms required when participating in a ACBHCS QA Office CQRT :

Mental Health Services Clinical/Quality Review Form: Each chart brought to the CQRT must include a form called the *Mental Health Services Clinical Review Form* or the *Mental Health Services Quality Review Form* (this form is also referred to as the *CQRT Request Form*). Please use the "Guide to Completing ACBHCS Clinical/Quality Review Form" when completing these forms. These forms are an official request for approval to authorize reimbursement for ongoing services. These forms will be used in either a Quality Review or Clinical Review during the regularly scheduled CQRT meeting. Approval decisions and CQRT feedback to programs will be noted on this form.

> Providers that are a part of the ACBHCS QA Office "New Provider CQRT" must complete a full Quality Review for each chart that requires authorization prior to being brought into the scheduled ACBHCS CQRT meeting. This completed CQRT form (both sides) will accompany the chart into the CQRT meeting. If the Supervisor checks "Yes" in the Recommended Approval box, s/he is certifying that the chart has been reviewed and 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 1-30 day return by the CQRT Chair. Note that, a "No" response would be unusual as it is expected that charts and forms would be returned to the clinician for correction **prior** to the CQRT meeting.

CQRT Minutes: The provider must complete this form with the client's name, the provider reporting unit, and the client's INSYST number. After each review, the chairperson will indicate whether or not the chart has been approved, or is required to be returned to the next CQRT meeting due to deficiencies.

Chart Requirements:

The following list of documentation categories must be easily located in any chart brought to the CQRT. Each category has a distinct set of documentation requirements that follow the Regulatory Compliance Tool checklist. The list is intended to guide clinicians to create and maintain a well-documented chart that meets the mandatory CA-DHCS and ACBHCS criterion for approval of ongoing services. **All of the below categories are fully detailed in the Alameda County ACBHCS Clinical Documentation Standards manual which is a companion manual to this CQRT manual.**

All staff should refer to their program's policies and procedures for complete chart requirements and the ACBHCS QA Manual, Section 8 Policy on Documentation Standards.

- Medical Necessity
- Intervention Criteria
- Service Necessity
- Informing Materials
- Special Needs
- Chart Maintenance
- Medication Order Sheet
- Assessment
- Client Plan

- Progress Note**SECTION IV: The CQRT Process:**

The CQRT process is a required review of all client charts. The CQRT process is in accordance with the California Department of Health Care Services (DHCS) policies and standards, and with policies established by ACBHCS. Clinical records that meet documentation standards will receive an authorization for the next cycle of mental health services. Depending on the issue(s), 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.

The ACBHCS QA CQRT consists of an ACBHCS Chairperson and qualified representatives (licensed clinician, waivered, and/or registered clinician, 2nd year student trainee) appointed by programs to bring their charts for review and authorization. Representatives should have attended the "Clinical Documentation Train the Trainer" prior to participating in the CQRT.

Programs must designate a consistent staff to regularly attend the CQRT as well as backup staff that are equally trained and established in both the CQRT procedures and the Medi-Cal and ACBHCS documentation standards. The designated staff must be licensed, waivered, or registered as a Licensed Practitioner of the Healing Arts (LPHA). During the meeting, agency representatives address questions raised about their programs' charts by other reviewers and also act as reviewers of other program's charts. Reviewers may identify documentation issues, make recommendations for corrective action and give positive feedback. The CQRT Chairperson provides final approval for ongoing services.

Chart Review:
At each CQRT Meeting fifteen percent (15%) of the total number of charts are required to receive an in-depth review, also referred to as a Quality Review. This Quality Review uses the Mental Health Services Quality Review form which lists questions regarding basic chart documentation standards. Charts receiving a Quality Review should be reviewed first. The other 85% of charts should receive a Clinical Review. 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. BHCS prefers that, if available, the previous reviewer reviews the return due to their familiarity with the specific issue.

Chart Review: Clinical Review:
The purpose of the Clinical Review is to ensure that the minimum documentation required is in place. Items reviewed during a Clinical Review are documentation standards and medical necessity, which if not done correctly could result in individual or full chart disallowances. A few examples of required Clinical Review items are Medical / Service Necessity, adequate Assessment/Plan, complete signatures, Client signature on the plan, etc. A Clinical Review is guided by the Clinical Review Regulatory Compliance form.

Chart Review: Quality Review:
A Quality Review is a comprehensive review of the chart. Elements reviewed for a Quality Review are all of the elements of a Clinical Review described above, along with a comprehensive review of other important charting elements. Elements reviewed are both items that may result in claims disallowances and items that are not known to result in claims disallowances. All of the applicable elements of a Quality Review are on the Quality Review Regulatory Compliance form.

Chart Reviews Procedures:
Complete the CQRT Request Form using the "Guide to Completing ACBHCS Mental Health Services Clinical/Quality Review Form" located on the Provider website.

Whether completing a Clinical or Quality Review, as concerns or deficiencies are found, they should be noted on the back side of the quality or clinical review sheet. When the review is completed, consultation will occur 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. Feedback about the strengths and/or alternative clinical approaches is also welcomed.

The CQRT Reviewer signs the form and indicates whether or not the chart has been approved for authorization as follows:

- **Full Authorization**: Check this box if the chart has been given a full cycle authorization.

- **30-Day Authorization**: Check this box if the chart has been given a provisional 30-day authorization and will be returned for a second review. When the chart is returned in 1 month, attach the CQRT Request Form which notes the needed corrections.

- **No Authorization**: The CQRT Chairperson will determine which charts do not receive authorization. Depending on the issue identified some or all types of services may be identified as no longer billable to Medi-cal until the issues are corrected. The CQRT Chairperson will also determine if claimed services needs to be backed out of INSYST. The following circumstances may prohibit the chart's authorization and/or require claimed services to be backed out of INSYST:

    - Medical Necessity has not been documented.
    - Service Necessity has not been documented.
    - An incomplete or absent Assessment.
    - An incomplete or absent Treatment Plan.
    - For 30-day Returns that were reviewed during the previous month's CQRT: Failure to correct items from the prior provisional 30-day authorization period.

After each chart review, the Chairperson will review the form, discuss the results with the provider representative, and then issue a "Full Authorization", a "30-Day Authorization", or "No Authorization." The Chairperson may provide comments, will indicate the date in which the chart is to be returned to CQRT, and then sign the form with a full signature.

Confidentiality:

If clinical or mandatory issues arise it is the reviewer's responsibility to discuss this with the agency representative of their follow up. If the reviewer is not satisfied the issue will be fully addressed they should then discuss the issue with the CQRT ACBHCS lead rather than breaking confidentiality and filing ethics or CFS/APS report.

Section V: Special Situations: Multiple Provider Agencies Serving One Client:

The MHP understands that in some situations, a client may receive services by more than one program because their needs cannot be met by one provider. 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. Mental health services found in duplication will be addressed on a case by case basis and may result in disallowances of claims and discontinuation of services by treatment provider(s).

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.

Multiple Reporting Units of One Provider

At times, clients receive services from multiple Reporting Units (RUs) of a single provider organization. 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 Assessments and Client Plans:

- Multiple Assessments and Client Plans – one for each program's RU; or
- Unified Assessment and Client Plan -- completed by the RU program with the earliest episode opening which must include distinct treatment goals and mental health objectives for each additional RU.

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

- Complete a unified Revised Assessment and Client Plan, noting the change in services; or
- Change to multiple Revised Assessments and 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 complete an Assessment and Treatment Plan and 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 organizations 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.

Clinical Review: Brief review of client chart documentation. See page 15.

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

Children's or Adult Mental Health Services Clinical/Quality Review form aka CQRT Request Form: This form is used to document a provider's or ACBHCS authorization of Medi-Cal Specialty Mental Health Services provided by a contracted provider program.

CQRT Minutes: This form is for a listing of all client charts brought to the CQRT for review; form is completed with each chart's approval decision during the CQRT meeting.

Episode Opening Date (EOD): This is the date the client episode was opened in InSyst and represents the first date of claimed services.

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. (Was HIPAA mentioned in manual?)

LPHA: Licensed Practitioner of the Healing Arts; licensed clinical staff (MD, PhD, MFT, LCSW, LPCC, LPCC-F) and staff who are registered with the California Board of Behavioral Sciences, usually registered MFT/ASW/ PCC interns; Psychologists who are waivered by the State to provide services; and Master's level Advanced Practice Nurses (Clinical Nurse Specialists and Nurse Practitioners who have national or state certification to practice independently.

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 Special Mental Health Services" Section Title 9, Chapter 11, Sect. 1830.205(b)(1)(A-R).

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

MHSA: Mental Health Services Act.

Program: An ACHBCS contracted provider or county-owned and operated clinic of Specialty Mental Health Services.

QA Office: Quality Assurance Office.

Quality Review: This is a comprehensive review of client chart documentation. See page 15.

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" Section Title 9, Chapter 11, Sect. 1830.205(b)(1)(A-R).

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.