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| **Medi-Cal Regulatory Compliance Tool - CLINICAL REVIEW (85% of charts)** | |
| Client Name: | Client PSP#: |
| **Admin Review Components** (If 1 or 2 are not compliant, do not send to CQRT and immediately return to individual responsible for correction) | |

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|  | **Yes** | **No** | **N/A** |
| 1. Required Assessment present and signed by staff with credentials to do so |  |  |  |
| 2. Required Treatment Plan present and signed by staff with credentials to do so. |  |  |  |
| 3. Applicable CANS/ANSA is present and completed by staff with credentials to do so. |  |  |  |
| 4. ACBHCS Screening Form indicates client meets moderate-severe criteria |  |  |  |
| 5. Informing Materials signature page completed and is signed on time |  |  |  |
| **Progress Notes (At minimum must review 3 most recent progress notes)** | | | |
| 6. Date of service |  |  |  |
| 7. Location listed |  |  |  |
| 8. Group service notes include # of clients in attendance (including both medical and non-medical clients) |  |  |  |
| 9. PNs signed and dated with designation: Licensed/Registered/Waivered/Trainee/MHRS/Adjunct |  |  |  |
| 10. Service provided while client was not in lock-out setting, IMD, or jail (flag all progress notes billed during potential lock out for clinician to review). |  |  |  |
| 11. Progress note was completed within the required timeframe per MHP (or designated late) |  |  |  |
| 12. Progress note documents the language that the service is provided in, as needed |  |  |  |
| 13. Progress note indicates interpreter services were used, and relationship to client is indicated, as needed |  |  |  |
| Admin Comments: | | | |

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| **Clinician Review Components** |

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| **Informing Materials/Releases** | | **Yes** | **No** | **N/A** |
| 18. Informed consent for medication(s), when applicable | |  |  |  |
| **Medical Necessity** | | | | |
| 19. Primary Diagnosis from CA-DHCS Medi-Cal included diagnosis list | |  |  |  |
| 20. Documentation support primary diagnosis(es) for treatment | |  |  |  |
| **Impairment / Intervention Criteria** | | | | |
| 21. Impairments are due to included diagnosis | |  |  |  |
| 22. Interventions address impairments identified | |  |  |  |
| **Assessment** | | | | |
| 29. (If reviewing for Initial Authorization) All required elements of Initial Assessment are complete. | |  |  |  |
| 30. (If reviewing for Initial Authorization) Initial Assess. complete within 60 days of episode opening; except for Level III by 4th hour of service; DR/DTI by first billed day; Crisis\Adult Res. by 72 actual hours. | |  |  |  |
| 31. If a previous assessment was used and an addendum was done to update the previous assessment, the assessment used was completed in the last 12 months (for within an agency) or 6 months (if the assessment was completed by another provider agency). | |  |  |  |
| 32. (If reviewing for Annual Authorization) All required elements of Annual Assessment are complete. | |  |  |  |
| 33. (If reviewing for Annual Authorization)Annual assessment is complete by first day of episode opening month (EOM) (for charts due for annual reauthorization) | |  |  |  |
| 34. Dx is established by licensed LPHA or co-signed by licensed LPHA for waivered/registered/2nd year trainee staff | |  |  |  |
| 35. Risk(s) to client and/or others assessed | |  |  |  |
| **Client Plan** | | | | |
| 45. Initial plan complete within 60 days of episode opening; except for Level III by 4th hour of service; DR/DTI by first billed day; Crisis\Adult Res. by 72 actual hours. | |  |  |  |
| 46. Annual client plan completed on time. (Applicable to charts on an Annual Authorization cycle). | |  |  |  |
| 47. Plan revised and signed when significant change (e.g. in service, diagnosis, focus of treatment, etc.). | |  |  |  |
| 48. Objectives in plan are consistent with impairment caused by diagnosis | |  |  |  |
| 49. Mental health objectives are specific, observable, and/or measurable with timeframes | |  |  |  |
| 50. Plan identifies proposed service modalities, their frequency and timeframes | |  |  |  |
| 52. Client’s risk(s) have a safety plan (DTS/DTO), Harm to self, at risk for DV, Abuse, etc.) | |  |  |  |
| 53. Plan signed/dated by Licensed LPHA/Registered/Waivered or by Trainee/MHRS/Adjunct w/co-signature. | |  |  |  |
| 54. Plan signed/dated by MD, if provider prescribed MH Rx | |  |  |  |
| 56. Plan signed/dated by client or legal representative when appropriate or documentation of client refusal or unavailability | |  |  |  |
| **Progress Notes (At minimum must review 3 most recent progress notes)** | | | | |
| 58. Correct CPT OR Correct InSyst Code (Medicare requires CPT codes). | |  |  |  |
| 59. Planned service modalities with corresponding service codes are in applicable plan. | |  |  |  |
| 60. Claims for planned services prior to assessment being completed meet minimum medical necessity and plan requirements | |  |  |  |
| 61. Face-To-Face & total times are documented | |  |  |  |
| 62. Notes for client encounters include that day’s evaluation/behavioral presentation | |  |  |  |
| 63. Notes for client encounters include that day’s staff intervention | |  |  |  |
| 64. Notes for client encounters include that day’s client response to intervention | |  |  |  |
| 65. Notes for client encounters include client and/or staff f/u plan | |  |  |  |
| 66. Services are related to the current client’s plan’s mental health objectives | |  |  |  |
| 67. Services provided do not include claiming for supervision, academic, educational services, vocational services, recreation, and/or socialization. | |  |  |  |
| 68. Services claimed do not include time spent transporting without providing SMHS interventions. | |  |  |  |
| 69. Services provided do not include time claimed for clerical/administrative/voicemails/no-shows | |  |  |  |
| 70. Services provided do not include time claimed that is payee related. | |  |  |  |
| Clinician Comments: | | | | |
| Reviewer Name: | Date: | | | |
| Reviewer Signature: | | | | |

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| **RC Item#** | **Comments by Supervisor/Reviewer** | **Follow up Comments** | **When item has been corrected, initial here** |
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| **Additional Comments** (if applicable) | |
| Client Name: | Client PSP #: |

Supervisor/Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

CQRT Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: