|  |  |
| --- | --- |
| **Medi-Cal Regulatory Compliance Tool – QUALITY REVIEW (15% 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) | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **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 (Minimum 6 notes or last 60 days)** | | | |
| 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 |  |  |  |
| 14. Allergies/adverse reactions/sensitivities or lack thereof noted in chart |  |  |  |
| 15. Allergies/adverse reactions/sensitivities or lack thereof noted prominently on charts’ cover or in EHR |  |  |  |
| 16. Client plan indicates the client or representative was offered a copy of the plan |  |  |  |
| Admin Comments: | | | |

|  |
| --- |
| **Clinician Review Components (Write Comments on opposite side)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Informing Materials/Releases** | **Yes** | **No** | **N/A** |
| 17. Releases of information, when applicable |  |  |  |
| 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 |  |  |  |
| **Service Necessity: MUST have both 23 and 24** | | | |
| 23. The mental health condition could not be treated by a lower level of care? (true=yes) |  |  |  |
| 24. The mental health condition would not be responsive to physical health care treatment? (true=yes) |  |  |  |
| **Chart Maintenance** | | | |
| 25. Writing is legible |  |  |  |
| 26. Signatures are legible |  |  |  |
| 27. Discharge/Termination date noted when applicable |  |  |  |
| 28. Emergency Info. Is in a designated location in file/EHR/InSyst |  |  |  |
| **Assessment** | | | |
| 29. (If reviewing for Initial Authorization) All required elements of Initial Assessment are complete. (Interim assessments do not include all required elements.) |  |  |  |
| 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. Psychosocial history |  |  |  |
| 36. Risk(s) to client and/or others assessed |  |  |  |
| 37. Client strengths/supports |  |  |  |
| 38. Hx of psychiatric medications prescribed |  |  |  |
| 39. Relevant medical conditions/hx noted & updated |  |  |  |
| 40. Mental health history assessed. |  |  |  |
| 41. Relevant mental status exam (MSE) |  |  |  |
| 42. Past & present substance exposure/substance use: Tobacco, alcohol, caffeine, CAM, Rx, OTC drugs, & illicit drugs |  |  |  |
| 43. Youth: Pre/perinatal events & complete dev. hx |  |  |  |
| 44. Required CANS/ANSA (N/A for Level III or meds-only) |  |  |  |
| **Client Plan** | **Yes** | **No** | **N/A** |
| 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. (for charts due for annual reauthorization) |  |  |  |
| 47. Plan revised when significant change (e.g. in service, diagnosis, focus of treatment, etc.). |  |  |  |
| 48. Plan is consistent with diagnosis |  |  |  |
| 49. Objectives in plan are consistent with impairment caused by diagnosis |  |  |  |
| 50. Mental health objectives are specific, observable, and/or measurable with timeframes |  |  |  |
| 51. Plan identifies proposed service modalities, their frequency and timeframes |  |  |  |
| 52. Plan describes detailed provider interventions for each service modality listed in the plan (recommended but not required.) |  |  |  |
| 53. Client’s risk(s) have a safety plan (DTS/DTO), Harm to self, at risk for DV, Abuse, etc.) |  |  |  |
| 54. Plan signed/dated by Licensed LPHA/Registered/Waivered or by Trainee/MHRS/Adjunct w/co-signature. |  |  |  |
| 55. Plan signed/dated by MD (if provider prescribed MH Rx) |  |  |  |
| 56. Coordination of care is evident, when applicable |  |  |  |
| 57. Plan signed/dated by client (or legal representative when appropriate) or documentation of client refusal or unavailability |  |  |  |
| 58. Plan contains Tentative Discharge Plan |  |  |  |
| **Progress Notes (Minimum 6 notes or last 60 days)** | | | |
| 59. Correct CPT OR InSyst Code (Medicare requires CPT codes) |  |  |  |
| 60. Planned service modalities with corresponding service codes are in applicable plan. |  |  |  |
| 61. Claims for planned services prior to assessment being completed meet minimum medical necessity and plan requirements |  |  |  |
| 62. Face-To-Face & total times are documented |  |  |  |
| 63. Notes for client encounters include **that day’s** evaluation/behavioral presentation |  |  |  |
| 64. Notes for client encounters include **that day’s** staff intervention |  |  |  |
| 65. Notes for client encounters include **that day’s** client response to intervention |  |  |  |
| 66. Notes for client encounters include client and/or staff f/u plan |  |  |  |
| 67. Services are related to the current client’s plan’s mental health objectives |  |  |  |
| 68. Services provided do not include claiming for supervision, academic, educational services, vocational services, recreation, and/or socialization. |  |  |  |
| 69. Services claimed do not include time spent transporting without providing SMHS interventions. |  |  |  |
| 70. Services provided do not include time claimed for clerical/administrative/voicemails/no-shows |  |  |  |
| 71. Services provided do not include time claimed that is payee related. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **RC Item#** | **Comments by Supervisor/Reviewer** | **Follow up Comments** | **When item has been corrected, initial here** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| **Additional Comments** (if applicable) | |
| Client Name: | Client PSP #: |

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

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