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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Program Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewer (name & title): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Open** File: □  **Closed** File: □ Tx Modality: \_\_ OP \_\_IOT Populations Served: \_\_Women \_\_Perinatal \_\_Men | | | | | | | | |
| Client ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Review Date: \_\_\_\_\_\_\_\_\_  DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **A. SIGNATURE TIME LINES: Medical Necessity & Tx Plan**  1. Episode Opening Date (EOD): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or N/A: \_\_\_  2. Date Medical Necessity Established \_\_\_\_\_\_\_\_\_\_\_. The Physician shall review the client chart, provide a written basis (criteria) for DSM diagnosis and legibly sign & date the determination within 30 days of the EOD.  3. Date of Initial Tx Plan: \_\_\_\_\_\_\_\_\_\_\_\_ within 30 calendar days of the EOD the beneficiary & counselor shall indicate their participation in the plan by legibly signing & dating the tx plan.  4. Date of MD signature on Tx Plan: \_\_\_\_\_\_\_\_\_ within 15 calendar days of counselor’s dated signature on the tx plan the MD shall sign the clt tx plan.  5. Counselor Tx Plan updates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_. Every 90 days from date of initial clt tx plan and 90 days thereafter or when a change in problem identification or focus of tx occurs the clt tx plan shall be updated and signed by the counselor & clt. If the clt is not available to sign the plan, a staff note must reflect efforts to meet with clt to review and sign the plan.    6. Physician Tx Plan Updates: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ within 15 calendar days of counselor signature the MD shall sign the clt updated plan indicating medical necessity for continued treatment.  7. Date of Physician & Counselor Justification for Continuing Tx Services (Med Nec): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. No sooner than 5 months and no later than 6 months after the clt’s EOD or date of most recent Justification for Continuing Tx Services the Counselor & Physician shall indicated medical necessity for continuing tx services. Additional Dates: \_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_ | | | | **B. PHYSICIAN: REVIEW & SIGNATURE** | | | | |
|  | Yes | | No | N/A |
| 1. Med Nec-SUD Admission |  | |  |  |
| 1. DSM Code Diagnosis |  | |  |  |
| 1. Initial Treatment Plan |  | |  |  |
| 1. Physical Examination |  | |  | Tx Plan |
| 1. Updated Treatment Plan |  | |  |  |
| 1. Justification for Cont. Tx |  | |  |  |
| 1. DOB or Term of Pregnancy |  | |  |  |
| 1. Medication Management |  | |  |  |
|  |  | |  |  |
| 1. **ADMISSIONS, NOTIFICATION & AGREEMENTS** | | | | |
| 1. \*Consent / Admission to Tx |  |  | |  |
| 1. Verification of DMC Eligibility |  |  | |  |
| 1. \*Statement of Non-Discrimination |  |  | |  |
| 1. \*Complaints & Appeal Process |  |  | |  |
| 1. \*Fair Hearing Rights |  |  | |  |
| 1. \*Program Rules |  |  | |  |
| 1. \*Fees & Payment Agreement |  |  | |  |
| 1. \*Access to Treatment Files |  |  | |  |
| 1. \*HIPAA Privacy/Confidentiality |  |  | |  |
| 1. \*42 CFR Part 2 |  |  | |  |
| 1. \*Release of Information |  |  | |  |
| 1. Emergency Contact: Name & # |  |  | |  |
| 1. \*Health Questionnaire |  |  | |  |
| 1. DOB/Gender/Client ID (InSyst) |  |  | |  |
| 1. Referrals Needed or Provided |  |  | |  |
| 1. Follow-up approval (6+ months) |  |  | |  |
| 1. Race/Ethnic Background |  |  | |  |
| 1. Address/Tele # |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
| \* *Documents Require Clt Signature & Date*  **Comments:**  Reviewer Initial: \_\_\_\_ Follow-up needed: \_\_Yes \_\_No | | | | |
| 1. **ASSESSMENT** | | | | **G. GROUP SESSION ROSTERS** | | | | |
|  | Yes | No | N/A |  | Yes | No | | N/A |
| 1. Comprehensive SUD Assmnt |  |  |  | 1. Session Date & Time Note |  |  | |  |
| 1. Housing/Ed/ Employment/Family |  |  |  | 1. Client’s Printed Name & Sig |  |  | |  |
| 1. Previous Tx (MH/SUD) History |  |  |  | 1. Start and End Time |  |  | |  |
| 1. Special Issues: CJ, CPS, MH, etc. |  |  |  | 1. Group Topic |  |  | |  |
| 1. Diagnosis |  |  |  | 1. Topic Relates to Clt Tx Plan |  |  | |  |
| 1. Oriented within 72 hrs. of EOD |  |  |  | 6. |  |  | |  |
| 1. Counselor Signature(s) and Date |  |  |  | 7. |  |  | |  |
| 1. Strengths/Risks/Goals/Objectives |  |  |  | **H. PROGRESS NOTES** | | | | |
| 1. Risk Assmnt: Suicide, Homicide |  |  |  | 1. Notes Reflect Relevant Care |  | |  |  |
| 1. Clinical Sum/Case Formulation |  |  |  | 1. Notes Reflect Tx Plan Goals |  | |  |  |
| 1. ASAM Placement |  |  |  | 1. Notes Signed w/i 7 Days of Ser |  |  | |  |
|  |  |  |  | 1. Notes Reflect Progress |  |  | |  |
| 1. **CLIENT TREATMENT RECOVERY PLAN** | | | | 1. B.I.R.P. or Other Note Format |  |  | |  |
| 1. Stage of Change |  |  |  | 1. Referrals Documented |  |  | |  |
| 1. Plan is individualized |  |  |  | 7. |  |  | |  |
| 1. Plan states Clients Goal(s) |  |  |  | 1. **MEDICATION ASSISTED TREATMENT** | | | | |
| 1. Plan states Client Strengths |  |  |  | 1. Physician Notes |  |  | |  |
| 1. Plan states Objectives and Goals |  |  |  | 2.Medication Mngt Notes |  |  | |  |
| 1. Plan states Barriers to Goals |  |  |  | 3.Medical Release-Coordinate Care |  |  | |  |
| 1. Plan Identifies Resources |  |  |  | 4. Client Medication History |  |  | |  |
| 1. Target Dates are Stated |  |  |  | 5. |  |  | |  |
| 1. Descrip & Freq of Counseling |  |  |  | **J. DISCHARGE PLANNING or Discharge Summary** | | | | |
| 1. Primary Counselor Identified |  |  |  | 1.Disch Plan Links to Tx Plan Goals |  |  | |  |
| 1. Client Participation Noted |  |  |  | 1. Plan Identifies Achievements |  |  | |  |
| 1. Signatures and Dates as Required |  |  |  | 3.Plan Identifies Relapse Triggers |  |  | |  |
| 1. Plan Updated When Appropriate |  |  |  | 4.Plan Describes Support Network |  |  | |  |
| 1. Clt Sig or Effort to Obtain Clt Sig |  |  |  | 5.Plan States Length of Tx |  |  | |  |
| 1. Total # of tx plans w/clt Signature |  |  |  | 6.Plan Provides Referrals |  |  | |  |
| 1. Total # of tx plans |  |  |  | 7.Plan States Prognosis |  |  | |  |
|  |  |  |  | 8.Preprd w/i 30 Days Prior to Disch |  |  | |  |
| **F. OTHER TREATMENT DOCUMENTS** | | | | 9. Summary- Completed w/I 30 days from date of last contact |  |  | |  |
| 1. Drug Screen/UA Results |  |  |  | **COMMENTS:**  Reviewer Initial: \_\_\_\_ Follow-up needed: \_\_Yes \_\_No | | | | |
| 1. Coordination of Care Indicated |  |  |  |
| 1. Attendance & Service Type Noted |  |  |  |
| 1. Attendance Exceptions Noted |  |  |  |
| 1. Progress Report(s) |  |  |  |
| 1. Child Care Provided |  |  |  |
| 1. Other Services e.g. transport |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **K. QUALITY IMPROVEMENT FEEDBACK** | | | | | | | | |
| Training and/or Supervision was provided to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the counselor/therapist on this date \_\_\_\_\_\_\_\_.  Trainer/Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Counselor/Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |