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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |