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| **SUD DMC-ODS Regulatory Compliance Tool - > Denotes Clinical Review - Not for NTP/OTP** | | | | | | |
| Client Name: | | | Type of Services: |  | | |
| Date of Next CQRT: | InSyst/PSP#: |  | | | RU: |  |
| **Clinician Review Components (Write Comments on opposite side)** | | | | | | |

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| **Informing Materials/Releases** | **Yes** | **No** | **N/A** |
| 1. Informing Materials/Consent to treat complete and signed on time |  |  |  |
| ***>2. SUD Programs*** *ROI* signed by opening date of services |  |  |  |
| 3. Additional Releases of information (ROIs), when applicable |  |  |  |
| >4. Informed consent for medication(s), when applicable |  |  |  |
| **Medical Necessity (for Authorization Period)** | | | |
| >5. For RES UM preauthorization completed and documents filed in chart |  |  |  |
| >6. Primary diagnosis on BHCS SUD DMC Included diagnosis list |  |  |  |
| >7. Documentation supports primary diagnosis(es) for treatment |  |  |  |
| >8. Dx written basis established by LPHA. Unlicensed LPHA has co-signature. |  |  |  |
| >9. LPHA establishing the diagnosis met face-to-face or telehealth with beneficiary or SUD counselor who conducted the intake assessment (for initial) / the primary SUD Counselor (for CSJ) |  |  |  |
| >10. Initial diagnosis and medical necessity complete within required timeframes: 48 hrs for WM RES, 5 days for residential, and 30 days for all other SUD programs. |  |  |  |
| >11. ALOC indicates level of service provided (or clinical rationale) |  |  |  |
| >12. ALOC Initial Assessment completed as required: WM RES >48 hrs, RES by day 5, All other SUD providers by day 30 |  |  |  |
| >13. ALOC Re-assessment completed as required (from date of admission): RES every 30 days, IOS every 60 days, and OS/RS every 90 days |  |  |  |
| >14. For Cont. Just. of Services, Counselor recommendation is complete |  |  |  |
| >15. Medical Necessity, including diagnosis for Cont. Just. of Services complete within required timeframe: 5-6 months from EOD or date of last CSJ. |  |  |  |
| **Chart Maintenance** | | | |
| >16. Writing is legible |  |  |  |
| >17. Required signatures present and include legibly printed name, signature, and date |  |  |  |
| 18. Discharge/Termination date noted when applicable |  |  |  |
| 19. Emergency contact information up to date with ROIs |  |  |  |
| 20. Emergency Info. Is in a designated location in file/EHR/InSyst |  |  |  |
| 21. Progress note documents the language that the service is provided in, as needed |  |  |  |
| 22. Progress note indicates interpreter services were used, and relationship to client is indicated, as needed |  |  |  |
| >23. Service provided while client was not in lock-out setting, IMD, jail, JH |  |  |  |
| **Medical** | | | |
| >24. Physical exam requirements are met (or goal in plan) |  |  |  |
| 25. Physical exam completed by an external physician meets agency exam requirements and was reviewed by agency MD, PA, or NP within 30 days of admission |  |  |  |
| 26. Allergies/adverse reactions/sensitivities or lack thereof noted prominently on charts’ cover or in EHR |  |  |  |
| 27. Physician consultation services are between agency physician and BHCS specified physician consultant |  |  |  |
| >28. For perinatal beneficiaries, record contains medical documentation of pregnancy or birth |  |  |  |
| >29. AOD programs have completed Health Questionnaire (DHCS 5103) |  |  |  |
| **Assessment** | | | |
| >30. Intake Assess. Is complete within required timeframes: >48hrs for WM RES, 10 days for residential, and 30 for all other programs. |  |  |  |
| >31. All required elements of Intake Assessment are complete |  |  |  |
| 32. Assessment updated when applicable |  |  |  |
| >33. Drug/alcohol use, history assessed |  |  |  |
| 34. Medical history assessed |  |  |  |
| 35. Psychiatric/psychological history assessed |  |  |  |
| 36. Social/recreational history assessed |  |  |  |
| 37. Financial status/history assessed |  |  |  |
| 38. Educational history assessed |  |  |  |
| 39. Employment history assessed |  |  |  |
| 40. Criminal history, legal status, treatment history assessed |  |  |  |
| >41. For perinatal women, additional perinatal items were assessed |  |  |  |
| >42. If SUD counselor completed Intake/Assessment, LPHA reviewed and co-signed |  |  |  |
| 43. Assessment includes a case formulation |  |  |  |
| **Client Plan** | **Yes** | **No** | **N/A** |
| >44. Initial plan complete within required timeframes (48hrs WM RES, 10 days RES, & 30 days for other SUD (use sig. date of LPHA/Counselor) |  |  |  |
| >45. Plan updated every 90 days from LPHA/Counselor signature date |  |  |  |
| >46. Plan revised when significant change (e.g. in service, diagnosis, focus of treatment, inaccurate frequency, etc.). |  |  |  |
| >47. Plan is consistent with diagnosis and medical necessity |  |  |  |
| >48. All problems identified in the assessment are addressed in the plan or deferred (with justification for deferral) |  |  |  |
| >49. Plan includes goals to be reached that addresses each problem |  |  |  |
| >50. Goals/Action Steps in plan are consistent with impairment to functioning and need for SUD treatment |  |  |  |
| >51. Goals/Action steps are specific, observable, and/or measurable with target dates |  |  |  |
| >52. Plan includes service descriptions (type of counseling) and frequency |  |  |  |
| >53. Plan includes ICD-10 code and DSM-5 name of diagnosis |  |  |  |
| >54. If physical exam indicates significant illness, plan includes goal for tx |  |  |  |
| >55. If client has not had a physical exam in past 12 months, the plan includes a goal to get an exam |  |  |  |
| >56. Client’s risk(s) have a safety plan (DTS/DTO), Harm to self, at risk for DV, Abuse, etc.) |  |  |  |
| >57. Plan has primary SUD Counselor/LPHA printed name, signature, date |  |  |  |
| >58. Plan completed by SUD Counselor has LPHA co-signature by due date |  |  |  |
| >59. Plan indicates who is client’s “primary” counselor/LPHA |  |  |  |
| 60. Coordination of care is evident, when applicable |  |  |  |
| >61. Plans signed/dated by client (or legal representative when appropriate) or documentation of client refusal or unavailability within plan due dates |  |  |  |
| 62. Plan contains Tentative Discharge Plan |  |  |  |
| **Required # of Progress Notes to Review:**  **For Clinical Review: 14 day or minimum of 3 notes**  **For Quality Review: 30 days or minimum of 6 notes** | | | |
| **Progress Notes (ALL Programs)** | | | |
| >63. Daily note includes date of service |  |  |  |
| >64. Planned service modalities with corresponding service codes are in applicable plan |  |  |  |
| >65. Correct procedure code or service type indicated |  |  |  |
| >66. Notes indicate location of service: in-person, telephone, telehealth |  |  |  |
| >67. All include the topic or purpose of the session |  |  |  |
| >68. All include legibly printed name, signature, and date |  |  |  |
| >69. All community services indicate how provider ensured confidentiality |  |  |  |
| >70. All notes are completed within 7 days of the service date |  |  |  |
| >71. Services are related to the current treatment plan goals |  |  |  |
| >72. Services provided do not include time claimed for clerical/ administrative/ voicemails/ no-shows |  |  |  |
| >73. Services provided do not include claiming for supervision, academic, educational services, vocational services, recreation, UA lab fees, and/or socialization, Discharge Summary, etc. |  |  |  |
| >74. Documentation time is reasonable, substantiated by content, & w/date |  |  |  |
| >75. All include a description of progress on treatment plan problems, goals, action steps, objectives, and/or referrals |  |  |  |
| >76. All include info on the beneficiary's attendance, including the date, start and end times of each service |  |  |  |
| >77. Face-to-face, travel, and total times are documented |  |  |  |
| >78. Services provided by allowable staff within their scope of practice |  |  |  |
| >79. Medication services provided are within established requirements |  |  |  |
| >80. Notes for client encounters include client and/or staff f/u plan |  |  |  |
| **Progress Notes (RES ONLY)** | | | |
| >81. A daily note is completed for each day at the program |  |  |  |
| >82. At least one hour of clinical services documented daily |  |  |  |
| >83. 20 hours of structured therapeutic activities documented per week |  |  |  |
| >84. ASAM 3.1 = 7+ or ASAM 3.5 = 12+ of documented f2f clinical hours documented per week |  |  |  |
| >85. Only reimbursable activities are claimed in the note |  |  |  |
| >86. Daily notes include a narrative summary of progress on treatment plan, problems, goals, action steps, objectives, and/or referrals |  |  |  |
| >87. Daily notes include a record of attendance at each counseling session including date, start/end times, and topic of the session |  |  |  |
| **Group Notes/Sign-In Sheets** | | | |
| >88. Group notes include the number of participants |  |  |  |
| >89. Group notes include co-facilitator’s name and signature |  |  |  |
| >90. Group claims with co-facilitators are documented correctly |  |  |  |
| >91. There is a group sign-in sheet for every group counseling session |  |  |  |
| >92. Group sign-in sheet includes the topic of the session |  |  |  |
| >93. Group sign-in sheet includes the date and start/end time |  |  |  |
| >94. Each participant that attended has legibly printed name, signature |  |  |  |
| >95. SUD Counselor/LPHA who conducted group has legibly printed their name and signed the sign-in sheet |  |  |  |
| >96. Adults are not in groups with beneficiaries 17 or younger unless at a certified school site |  |  |  |

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| **Reviewer Comments** *(remember to include the referenced item numbers and use additional comments sheets if necessary):* | | | | |
| Supervisor/Reviewer Signature: | |  | Date: |  |
| CQRT Reviewer Signature: |  | | Date of review: |  |