Quality Improvement Plan or Plan of Correction
Organization Name, RU
Responsible Quality Assurance Staff Person's Name, Credentials, Direct Phone #, & Email

Quality Review/Claims Item	Plan of Correction	BY
Example: 14. Informed Consent for Medication(s), when applicable?	**Example:** Plan of Correction: MDs now add dosage & range to Consent form. All current MDs have been advised of this practice & moving forward since Nov 1, are including this DHCS requirement. New MDs will be trained to this standard. Please see attached revised medication consent form and Memo of notice to MDs of the requirement.	**Example:** November 1, 2014
Quality review items: address all from audit results which are < 95%.		
9. Informing Materials signature page completed and signed on time? (within 30 days of EOD and then annually by EOD) OR if late, documents reason in progress notes	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
10. ACBHCS Screening Tool has been completed prior to the opening of the client episode, prior to the reauthorization of services, and/or at the time of any Client Plan update?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
11. The mental health condition could not be treated at a lower level of care?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
12. Primary diagnosis from DHCS Medi-Cal Included Diagnosis list is included?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
13. Documentation (assessment, client plan, PN's) supports primary diagnosis (es) for TX?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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14. Impairment Criteria: the focus of TX is one of the following as a result of Dx: a. Significant impairment in important area of life functioning; b. Probable significant deterioration in an important area of life functioning; c. Probable the child won't progress developmentally, as appropriate; d. If EPSDT: MH condition can be corrected or ameliorated.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
15. The mental health condition would not be responsive to physical health care treatment?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
16. Focus of proposed intervention addresses medically necessity criteria AND they will diminish impairment, or prevent significant deterioration in important area of life functioning, or will allow the child to progress developmentally as appropriate. (If EPSDT, condition can be corrected or ameliorated.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
17. Presenting problems and relevant conditions included?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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18. Assessment includes psychosocial history?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
19. Assessment lists current psychiatric medications?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
20. Assessment includes a mental status exam (MSE)?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
21. Risk(s) to client assessed?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
22. Risk(s) to others assessed?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
23. Assessment for youth includes pre/perinatal events and complete developmental history?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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24. Client strengths/supports are included?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
25. Allergies/adverse reactions/sensitivities OR lack thereof noted in record?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
26. Allergies/adverse reactions/sensitivities OR lack thereof noted prominently on chart cover, or if an EHR, is it in the field/location designated by the clinic?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
27. Relevant medical conditions/hx noted?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
28. Assessment adequately notes client's mental health history?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
29. Past and present substance exposure/substance use of tobacco, alcohol, caffeine, CAM, Rx, OTC drugs, and illicit drugs assessed and noted?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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30. CFE or CANS/ANSA completed for relevant audit period? (N/A for FSP/Brief Service Programs)	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
31. Dx is established by a licensed LPHA OR co-signed by licensed LPHA if established by a waivered staff or registered intern?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
32. Assessment completed and signed by all required participants on time.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
33. Is the Client Plan consistent with the diagnosis and addresses mental health impairments/symptoms?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
34. Are the Mental health objectives listed in the Client Plan observable or measurable with time frames (baselines are recommended)?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
35. Does the Client Plan identify proposed service modalities, their frequency, and time frames.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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36. The Client Plan describes detailed provider interventions for each service modality listed in the Plan?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
37. Identified Risk(s) to client have plan for containment, if applicable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
38. Identified Risk(s) to others have a plan for containment, if applicable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
39. Is Coordination of care evident, when applicable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
40. Is the Client Plan signed/dated by LPHA (if licensed, credential is listed)?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
41. Is the Client Plan revised when there are significant changes in service, diagnosis, focus of treatment, etc.?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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42. Is the Client Plan signed/dated by MD? (required if receiving medication services)	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
43. Is the Client Plan signed/dated by client or legal representative when appropriate, or documentation of client refusal or unavailability?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
44. Does the Client Plan indicate that the client/representative was offered a copy of the Plan?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
45. Was the Client Plan for relevant audit period completed on time?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
46. Does the Client Plan contain a Tentative Discharge Plan?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
47. Has the Client's cultural and communication needs, or lack thereof, been noted in relevant client plan/assessment?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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48. If identified, were cultural and communication needs addressed as appropriate?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
49. Have the Client's physical limitations, or lack thereof, been noted?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
50. If identified, were physical limitations addressed as appropriate?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
51. Med. log (or note) updated at each visit with date of Rx?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
52. Med. log (or note) updated at each visit with drug name?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
53. Med. log (or note) updated at each visit with drug strength/size?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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54. Med. log (or note) updated at each visit with instruction/frequency of Rx?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
55. Med. log (or note which requires signature) updated at each visit with prescriber's signature/initials?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
56. Informed Consent for Medication(s), when applicable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
57. The informed consent form for medications includes: Rx name, dosage or range expected, uses/effects, risks/side effects, client signature, client name or ID?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
58. E/M progress notes are compliant with E/M documentation standards.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
59. There is a progress note (PN) for every service contact?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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60. Correct CPT and/or INSYST service codes?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
61. Date of service indicated and correct?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
62. Location of service indicated and correct?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
63. Face-to-Face Time and Total Time are documented	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
64. Time documented on PN equals time claimed?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
65. Time noted for documentation of service is reasonable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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66. Documentation content supports amount of time claimed?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
67. Notes for client encounters include description of that day's evaluation/behavioral presentation?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
68. Notes for client encounters include description of that day's staff interventions?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
69. Notes for client encounters include description of that day's client response to interventions?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
70. Notes for client encounters include description of client's and/or staff's plan/follow-up?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
71. Group service notes include # of clients served, if applicable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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72. Services are related to mental health objectives listed in Client Plan?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
73. Unresolved issues from prior services addressed, if applicable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
74. PN is signed and dated with designation: License/registration/waiver/MHRS/Adjunct?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
75. Completion line after signature (N/A If EHR notes)?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
76. Service provided while client was NOT in a lock-out (i.e. IMD, jail, juvenile hall, etc)?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
77. Service provided was NOT for supervision, academic educational svc, vocational svc, recreation and/or socialization?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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78. Service provided was NOT transportation?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
79. The service was NOT clerical (i.e. making copies, voice mail, scheduling appointments with client, etc.)?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
80. The service was NOT payee related?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
81. Progress note was completed within the required timeframe per MHP?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
82. Progress note documents the language that the service was provided in (or note in Assessment that client is English-speaking and all services to be provided in English)?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
83. Progress note indicates interpreter services were used, and relationship to client is indicated, if applicable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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84. Admission date is noted correctly? (EOD noted in chart should match INSYST)	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
85. Emergency contact info in designated location in file/EHR?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
86. Releases of information, when applicable?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
87. Writing is legible? (Areas reviewed: Assessments, Client Plans, non-clinical forms, PN's & MD docs)	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
88. Signatures are legible (or printed name under signature or signature sheet)? (Areas reviewed: Assessments, Client Plans, non-clinical forms, PN's & MD docs)	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
89. Filing is done appropriately?	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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90. Client identification is present on each page in the clinical record? (Areas reviewed: Assessments, Client Plans, non-clinical forms, PN's & MD documents)	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
91. Discharge/termination date noted correctly, when applicable?[1] (Discharge/termination date noted in chart should match INSYST)	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
Claims disallowances: address all reasons from audit results.		
1. Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A- R).	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Non-Included Dx.		
b) No Current Assessment present.		
c) Assessment not signed by LPHA.		
d) *List One:* Diagnosis is not established by licensed LPHA OR not co-signed by licensed LPHA if established by a waivered staff or registered intern.		

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2. Documentation in the medical record does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments: A significant impairment in an important area of life functioning; A probability of significant deterioration in an important area of life functioning; A probability the child will not progress developmentally as individually appropriate; or for full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) No Current Assessment present.		
b) Assessment not signed by LPHA.		
c) Client meets only Mild-Moderate Screening Criteria--Client to now be discharged.		
3. Documentation in the medical record does not establish that the focus of the proposed intervention is to address the condition identified in CCR, title 9, chapter 11, section 1830.205(b)(2)(A),(B), (C) - (see	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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below): A significant impairment in an important area of life functioning; A probability of significant deterioration in an important area of life functioning; A probability the child will not progress developmentally as individually appropriate; and for full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.		
a) No Current Assessment present.		
b) Assessment not signed by LPHA.		
4. Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following: Significantly diminish the impairment; Prevent significant deterioration in an important area of life functioning; Allow the child to progress developmentally as individually appropriate; or for full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) No Current Assessment present.		

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b) Assessment not signed by LPHA.		
5. Initial client plan was not completed within the time period specified in the Mental Health Plan (MHP's) documentation guidelines, or lacking MHP guidelines, within 60 days of the intake unless there is documentation supporting the need for more time.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Service claimed does not relate back to a current mental health objective in Client Plan.		
b) Service modality claimed is not indicated in Client Plan.		
c) No Client Plan for date of service.		
d) Client Plan is missing required staff signature(s) for date of service.		
6. The client plan was not completed, at least, on an annual basis or as specified in the MHP's documentation guidelines.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Service claimed does not relate back to a current mental health objective in Client Plan.		
b) Service modality claimed is not indicated in Client Plan.		
c) No Client Plan for date of service.		

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d) Client Plan is missing required staff signature(s) for date of service.		
7. No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) No client (or guardian) signature on Client Plan.		
b) Late client (or guardian) signature on Client Plan for date of service, w/o documentation of reason.		
8. For beneficiaries receiving Therapeutic Behavioral Services (TBS), no documentation of a plan for TBS.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
9. No progress note was found for service claimed.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) PN missing.		
b) PN incorrectly dated.		
10. The time claimed was greater than the time documented.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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a) Documentation *content* does not support amount of time claimed.		
b) Time documented on PN does not equal time claimed (overbilled).		
c) Time noted for documentation is excessive.		
d) Time on PN is not broken down into face-to-face (time based codes—crisis, ind. psychotherapy, E/M when >50% of face-to-face time is spent as Counseling & Coordination of Care) and total time.		
11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation. (e.g. Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11.)	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Psychiatric Inpatient Lock out setting (and not C/M placement services 30 days prior to documented d/c).		
12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____	

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minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).	__ Other:	
13. The progress note indicates that the service provided was solely for one of the following: Academic educational service; Vocational service that has work or work training as its actual purpose; Recreation; or socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Non- billable service – educational related.		
b) Non- billable service – vocational related.		
c) Non- billable service – recreational related.		
d) Non- billable service – social group related.		
14. The claim for a group activity was not properly apportioned to all clients present.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Group service note does not include # of clients served.		

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15. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Missing Provider signature.		
b) Missing required LPHA co-signature.		
16. The progress note indicates the service provided was solely transportation.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Non- billable activity – transportation related.		
17. The progress note indicates the service provided was solely clerical.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Non- billable activity – clerical related.		
b) Non- billable activity – administrative (i.e. _____) related.		
c) Non- billable activity – voicemail activity.		
d) Non- billable activity – No Show.		
e) Non- billable activity – making appointment w/client related.		
18. The progress note indicates the service provided was solely payee	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____	

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related.	__ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Non- billable activity – payee related.		
19a.No service was provided.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
a) Absolute Incorrect Service Code, "Service code should be _____".		
b) PN does not include Clinician's Intervention component.		
c) Extensive cut & paste activity for Intervention component PN.		
d) Case closed, cannot bill.		
e) Client deceased, cannot bill.		
f) Non-Billable Activity for Completion of ACBHCS Screening Tool.		
g) Illegible Progress Note (to degree—no actual content for intervention component).		
h) Duplication of Services (and list one: Same service billed twice by same provider OR by different providers		

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without documentation to support co-providers).		
i) Non- billable activity – supervision related.		
19b. The service was claimed for a provider on the Office of Inspector General List of Excluded individuals and Entities.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
19c. The service was claimed for a provider on the Medi-Cal suspended and ineligible provider list	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
19d. The service was not provided within the scope of practice of the person delivering the service.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	
20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons: For the convenience of the family, caregivers, physician, or teacher; To provide supervision or to ensure compliance with terms and conditions of probation; To ensure the child's/youth's physical safety or	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	

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the safety of others, e.g., suicide watch; or to address conditions that are not a part of the child's/ youth's mental health condition.		
21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.	__ Training of _____ by _____ at _____ on _____ __ Training of _____ by _____ at _____ on _____ __ CQRT review of _____ by _____ at _____monthly, through _____ __ Form, named _____ revised to include _____ __ Other:	