CHILDREN'S MENTAL HEALTH SERVICES
CLINICAL/QUALITY REVIEW

Date: _____ ☐ **returned after 30 day provisional authorization***

*attach the previous CQRT form to this one

Client Name:
Client PSP# :
Provider Name: **Program:**
Reporting Unit:
Clinician:
Admission Date:
Next Cycle:
From: **To:**

Class:
- ☐ Regular Education
- ☐ Independent Study
- ☐ Resource Specialist Program
- ☐ Special Day Class
- ☐ Counseling Enriched Special Day Class
- ☐ NPS Day Treatment
- ☐ School-Based Day Treatment

Handicapping Condition(s):
- ☐ Emotionally Disturbed
- ☐ Specific Learning Disability
- ☐ Learning Handicapped
- ☐ Other Handicapping condition: _____

AB3632: ☐ **Yes** ☐ **No**

Request for:

OUTPATIENT MENTAL HEALTH SERVICES (check all that apply)
- ☐ Individual/Family Treatment/Collateral
- ☐ Group Treatment
- ☐ Rehabilitation Services
- ☐ Case Management/Brokerage Services
- ☐ Medication Services

DAY TREATMENT SERVICES (check one)
- ☐ INTENSIVE: 90 Days (3 months)
- ☐ REHABILITATIVE: 180 Days (6 months)

Service Necessity (current or within past six months):
- ☐ Psychiatric hospitalizations.
- ☐ Suicidal/homicidal ideation or acts.
- ☐ Psychotic symptoms.
- ☐ At risk for out of home placement or change in placement.
- ☐ Severe school and social impairment due to mental disorder.

Symptoms and Behaviors Supporting Current Diagnosis and Service Level: _____

Current Level of Functioning and Response to Treatment Interventions:

Tentative Discharge Date and Aftercare Plan:

Clinician:
Signature and Date

Clinical Supervisor: **Recommended Approval:** ☐ **Yes** ☐ **Needs Discussion**
Signature and Date

CQRT Reviewer: **Recommended Approval:** ☐ **Yes** ☐ **Needs Discussion**
Signature and Date

Rationale for Continuation of Services:
- ☐ **At risk for psychiatric hospitalizations**
- ☐ **Suicidal/homicidal ideation or acts**
- ☐ **Severe or psychotic symptoms**
- ☐ **At risk for out of home placement or change in placement**
- ☐ **Severe school and social impairment due to a mental disorder**
- ☐ **Other (specify)**

Committee Comments:

Provisional Authorization: ☐ **Yes** ☐ **No**
Start Date: **End Date:**

Committee Chair:
Signature and Staff Number
Approval Date:

Quality Review: ☐ **Approved** ☐ **Return to Supervisor** *(See Back Page)*

Reviewer:
Signature and Staff Number
Review Date:

QUALITY REVIEW - Regulatory Compliance

Medical Necessity:	Yes	No	N/A
Five Axes DSM-IV included Diagnosis for Specialty Mental Health Services			
Impairment Criteria: ***Must have one of the following as a result of diagnosis:***			
1. A significant impairment in an important area of life functioning, or	☐	☐	☐
2. A probability of significant deterioration in an important area of life functioning, or	☐	☐	☐
3. A probability that the child will not progress developmentally as individually appropriate.	☐	☐	☐
4. Children covered under EPSDT qualify if they have a mental disorder, which can be corrected or ameliorated. (Current DHS EPSDT regulations apply.)	☐	☐	☐
Intervention Criteria: Must have 1, 2, and 3			
1. The focus of proposed intervention is to address the condition identified in the Impairment Criteria, and	☐	☐	☐
2. It is expected the client will benefit from the proposed intervention by diminishing the impairment or preventing significant deterioration in an important area of life function, and/or	☐	☐	☐
2A. It is probable the child will progress developmentally as individually appropriate, or	☐	☐	☐
2B If covered by EPSDT can be corrected or ameliorated, and	☐	☐	☐
3. The condition would not be responsive to physical health care-based treatment.	☐	☐	☐
Service Necessity:			
1. What is the risk of the client's level of dysfunction increasing if fewer services were provided? Low 1 2 3 4 5 High			
2. Can a different type/level of Speciality Mental Health Services meet this client's need for services reasonably well?	☐	☐	☐
3. Can a primary care physician or private practitioner/therapist meet this client's need for services (a lower level of care) reasonably well?	☐	☐	☐
Evaluation and Consent:			
1. Prenatal, perinatal and comprehensive developmental history is present.	☐	☐	☐
2. Annual Community Functioning Evaluation or Youth Performance Outcome Measures are present.	☐	☐	☐
3. HIPAA Privacy Notice provided.	☐	☐	☐
4. Freedom of Choice is documented.	☐	☐	☐
5. Beneficiary Problem Resolution form is present.	☐	☐	☐
Legibility:			
Writing and signatures are legible.	☐	☐	☐

Treatment Plan:	Yes	No	N/A
1. Initial Treatment or Service Plan completed by 30 days of opening episode date.	☐	☐	☐
2. Treatment Plan reviewed every 6 months from opening episode date, updated or revised every 6 months and rewritten annually.	☐	☐	☐
3. There is a revised Treatment or Service Plan when there was a significant change in plan, service, diagnosis, problem, or focus of treatment.	☐	☐	☐
4. Treatment Plan includes objectives and planned interventions addressing identified impairments and strengths.	☐	☐	☐
5. Objectives are measurable.	☐	☐	☐
6. Treatment Plan Review (TPR) or Service Plan (SP) is signed and dated by LPHA.	☐	☐	☐
7. Treatment Plan Review signed and dated by MD, if the provider prescribes the medication.	☐	☐	☐
8. Treatment Plan Review signed and dated by client/family/guardian.	☐	☐	☐
Progress Notes:			
Progress Notes are related to the TPR/SP's goals and objectives.	☐	☐	☐
Mental Health Services:			
1. All Progress Notes are signed and dated with title.	☐	☐	☐
2. Procedure, location, date, and amount of time documented.	☐	☐	☐
Intensive Day Treatment/Crisis Residential:			
1. Daily Progress Notes are signed/co-signed and dated by LPHA or LVN, PT, or MHRS.	☐	☐	☐
2. Weekly summaries are signed/cosigned and dated by LPHA.	☐	☐	☐
4. Placement Authorization is in chart for all Episodes opened after July 1, 2003.	☐	☐	☐
Rehabilitative Day Treatment/Residential:			
1. Weekly summaries are signed/co-signed and dated by LPHA or LVN, PT or MHRS.	☐	☐	☐
2. Each date of service is identified in Progress Note.	☐	☐	☐
3. Placement Authorization is in chart for all Episodes opened after July 1, 2003.	☐	☐	☐
Special Needs:			
1. The client's cultural and linguistic needs are documented.	☐	☐	☐
2. Information is provided to a client with visual and hearing impairments, if applicable.	☐	☐	☐
Therapeutic Behavioral Services (TBS)			
TBS services are documented in the TP, if applicable.	☐	☐	☐