Behavioral Health Department
Alameda County Health

# Clinical Quality Review Team (CQRT) Glossary

## Providers of Intensive Care Coordination (ICC) or Intensive Home-Based Services (IHBS)

**Scope:** This document should be used by providers of ICC or IHBS to children and young adults up to 21 years of age.

**Purpose**: It clarifies the requirements for each of the checklist items on the *ICC CQRT Checklist* that is published on the QA Manual page of the ACBHD Provider website.

| CQRT Checklist Items | Glossary |
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| **Informing Materials/Consents** | |
| 1. Informing Materials page is signed/initialed and on time. | • The Informing Materials packet is reviewed with the client/authorized representative at Intake, annually thereafter and upon request.<br>• The Informing Materials Acknowledgement of Receipt page is signed and dated.<br>• Resource: BHCS Providers Website \| Informing Materials List (acgov.org) |
| 2. Telehealth Consent documentation requirements are met, as applicable. | Written or verbal telehealth consent requirements are met:<br><br>• Obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services prior to the initial delivery of covered services via telehealth (synchronous audio and video) or telephone (audio only).<br>• Explain specific information to beneficiaries regarding the use of telehealth.<br>• Document in the beneficiary's medical record their verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services.<br><br>See Section 7 of the QA Manual page for details of what should be included in the consent. |

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| 3. Documentation of informed consent to prescribe psychiatric medication(s), when applicable. | For all prescribed psychiatric medications, the following information must be included in the note:<br>• The nature of the patient's mental condition<br>• The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff.<br>• The reasonable alternative treatments available<br>• The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications.<br>• The probable side effects of these drugs known to commonly occur, and any side effects likely to occur with the patient Possible side effects of taking anti-psychotic medication beyond three months, including persistent involuntary movement of the face or mouth, possible similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.<br>• A notation that the patient understands the nature and effect of medications and consents to the administration of those medications.<br>Resource: See Section 7 of the QA Manual |
| **Assessment & Medical Necessity** | |
| 4. Required assessment is present and signed by staff with credentials to do so. If not present, the reason for the delay is noted. | • The Mental Health Assessment includes all required CalAIM domains.<br>• The assessment is signed by a registered, waivered, or licensed LPHA.<br>• Includes required co-signatures based on the scope of license.<br>• If not present, the reason for the delay is noted in a progress note.<br>Resource: CalMHSA Documentation Guides<br>ICC resource: Alameda County Behavioral Health |
| 5. Most recent assessment demonstrates need for ICC services | • Assessment clearly documents the client's need for ICC services through screening for ICC/IHBS and TFC services. |

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| | • The clinical formulation of the assessment includes information about the client's need for ICC and how they are expected to benefit from these services. |
| 6. The client's physical limitations, cultural and communication needs, or lack thereof, are noted. | Psychosocial factors noted on the assessment, or elsewhere in the chart, include information about the client's physical, cultural, and communication needs, or lack thereof. |
| 7. Documentation of coordination of care is present, anywhere in the chart, as clinically appropriate. | • It is evident from the assessment and/or progress notes that efforts are being made to coordinate care with other providers as clinically appropriate.<br>• Examples include, but aren't limited to, the presence of Releases of Information (ROI) authorizing communication with other service providers and/or documented efforts to communicate with other providers.<br>• When required, ROI forms are completed in full, signed and dated by the client or their authorized representative. |
| 8. CANS is finalized and signed on time (with all sections completed) by staff with the credentials to do so. | • Childhood Assessment of Needs and Strengths (CANS) is completed within 60 days of the Episode Opening, every 6 months, and at discharge.<br>• Provider must have Praed Foundation CANS Certification prior to administering the CANS and adequate knowledge and clinical understanding of the client to comprehensively complete all CANS domains in collaboration with the client.<br>• A copy of the referring agency's most recent CANS will satisfy this requirement. |
| 9. PSC35 is present, or documentation of parent refusal/lack of response is in chart. | • The Pediatric Symptoms Checklist (PSC) must be completed within 60 days of the Episode Opening, every 6 months and at discharge.<br>• If not completed, there should be documentation of refusal or lack of response.<br>• A copy of the referring agency's most recent PSC-35 will satisfy this requirement.<br>• If a parent or caregiver is unable to complete the PSC-35, you may administer the PSC-Y to a youth over the age of 11 for self-report. |
| 10. MH diagnosis or suspected diagnosis (includes Z codes) is present. If suspected | • A Mental Health diagnosis is an important component of providing targeted, appropriate services.<br>• Documentation in the medical record must initially demonstrate that the beneficiary meets the specific access |

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| or Z code is used, notes indicate efforts to clarify the diagnosis. | criteria for each delivery system. If a diagnosis cannot be immediately established, specific Z Codes are allowed for billing and to start the Problem List.<br>• Z codes are acceptable during the assessment period, if a diagnosis cannot be established immediately, or for beneficiaries under 21 years of age who are experiencing significant trauma placing them at risk of future mental health conditions. These include those involved in child welfare, juvenile justice or homelessness.<br>• In the above situations, the following options can be used:<br>  ○ ICD-10 codes Z55-Z65 may be used by all providers, including an MHRS or other qualified staff and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).<br>  ○ ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP.<br>  ○ In cases where services are provided due to a suspected disorder that has not yet been diagnosed, LPHA and LMHP may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."<br>• If a Z code is used during the assessment phase, it should be clear why a diagnosis was not made and what efforts are being made to establish a diagnosis. For example, medical records requested from other providers, collateral sessions being scheduled with the family or school to gather more historical information, etc.<br>• The established diagnosis is supported by clinical notes. |
| 11. Meets Access Criteria and/or Medical Necessity | • This is a Disallowance Reason<br>• Documentation in the medical record must demonstrate that the client meets the specific access criteria for each delivery system.<br>• <u>Access Criteria (Persons Under 21 years of age):</u><br>  ○ The person is experiencing significant trauma placing them at risk of future mental health conditions. These include those who are homeless, involved in child welfare or juvenile justice or those who scored in the |

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| | high-risk range on a DHCS approved Trauma Screening tool (e.g. Pediatric ACES and Related Life-Events Screener (PEARLS) tool, ACE Questionnaire.<br>• Medical Necessity (Persons under age 21 and older): The service is necessary to correct or ameliorate a mental illness or condition discovered by a screening service. These services can be delivered to sustain, support, improve or make more tolerable a mental health condition.<br><br>Resource: Behavioral Health Screening Tool for Outpatient Services.pdf (acgov.org) |
| 12. If risk occurred in the past 90 days, there is a comprehensive risk assessment and safety plan. | • Risk refers to danger to self, danger to others or any other behaviors that might create risk of harm to the client or others.<br>• A comprehensive risk assessment and safety plan must be in the chart and reviewed with client. |
| **Problem List** | |
| 13. A Problem List is present and supported by the documentation in the chart. | • A Problem List should be started as soon as possible once the client is admitted.<br>• It should include all required components as noted in the CalMHSA Documentation Guides.<br>• End dates are added only when problems are resolved or deferred.<br>• In Clinician's Gateway (CG), the Archive option is only used if a problem is added to the chart in error.<br>• The problems on the list should be generally consistent with the chart notes and reflect the client's current issues. |
| **Progress Notes** | |
| 14. The progress note was signed (or electronic equivalent) by the person(s) providing the service and the service provided was within the scope of practice of the person delivering the service. | • Possible DHCS disallowance reason<br>• All progress notes include:<br>○ The specific service(s) provided to the client<br>○ Descriptions of the client's progress toward the goals identified in the treatment plan<br>○ Description of how interventions address client's mental health needs and/or Social Determinants of Health and planned action steps.<br>○ Date of service<br>○ Location of service<br>○ If the service is provided in a language other than English, the language is noted. |

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| | ○ Signed and dated by the person providing the service within their scope of license.<br>• Resource: See Guidelines for Scope of Practice (MH) in Section 12 of the QA Manual |
| 15. Progress Notes describe how interventions address beneficiaries' mental health needs or Social Determinants of Health and planned action steps. If non-reimbursable services were provided, the note clarifies that the time was not claimed. | • This is a DHCS Disallowance Reason<br>• Non-reimbursed services including the following:<br>○ Academic educational service<br>○ Vocational service that has work or work training as its actual purpose. o Recreation<br>○ Socialization consisting of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.<br>○ Transportation<br>○ Clerical<br>○ Payee Related |
| 16. Should more than one provider render a service, either to a single client or to a group, there is least one progress note per client, and it includes all required components. | Should more than one provider render a service, either to a single client or to a group:<br><br>1) At least one progress note per client must be completed<br>2) The note must be signed by at least one provider<br>3) The note shall clearly document the specific involvement and duration of direct patient care for each provider of the service and a brief description of the client's response to the service.<br><br>If group services were provided, a Participant List must be kept for all groups outside of the clinical record and available if requested by ACBHD.<br><br>Source: BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services.pdf |
| 17. Child and Family Team Meeting (CFT) Care Plan & Meeting Minutes are present and include the required information. | • CFT Meeting Minutes are present within the first 30 days of services and contain a care plan stating that ICC services are being provided.<br>• Henceforth, CFT Meeting Minutes are present within the chart demonstrating that a CFT occurred, at a minimum, every 90 days stating ongoing ICC services are being provided.<br>• If CFT meetings are not held per requirements, progress notes document barriers and efforts to schedule. |

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| | • CFT Meeting Minutes demonstrate that CANS items were discussed at meeting. |
| 18. If CFT determines that IHBS is needed, there is documentation of a referral to IHBS services. | • If assessment and CFT meeting minutes document client's need for IHBS services, a referral is made for IHBS services.<br>• The referral is documented in a progress note.<br>• The CFT Meeting Minutes must document review of the need for IHBS services every 6 months<br>• A request for re-authorization of IHBS services is documented. |
| 19. The Care Plan reflects IHBS services, if provided. | CFT Meeting Minutes must include IHBS services as part of the care plan if the client is receiving these services. |