

Clinical Quality Review Team (CQRT) Glossary Specialty Mental Health Services Outpatient Programs

Informing Materials/Consents	
<p>1. Informing Materials <i>Acknowledgement of Receipt and Consent to Services</i> page is signed and on time and meets all requirements.</p>	<ul style="list-style-type: none"> • The ACBHD Informing Materials documents are reviewed with and offered to member/authorized representative before or during the intake appointment, when there are substantial changes to the documents and when requested by member/authorized representative. • Informing Materials consist of the following documents/information: <ol style="list-style-type: none"> 1. Integrated Member Handbook 2. Advance Directive Educational Material 3. Provider Directory 4. Other Consent Forms, as appropriate 5. Notice of Privacy Practices (also embedded in Integrated Member Handbook) 6. Acknowledgement of Receipt & Consent to Services • The Informing Materials <i>Acknowledgement of Receipt and Consent to Services</i> page is fully completed, with relevant boxes checked, and signed based on above timeframes. • Minor Consent requirements are followed. • For members whose primary language is not English, there is evidence of Informing Materials being offered to and reviewed with the member in their primary language. <p>Resources:</p> <ul style="list-style-type: none"> ○ Informing Materials webpage ○ Minor Consent TIPS
<p>2. Documentation of informed consent to prescribed psychiatric medication(s), when applicable.</p>	<p>For all psychiatric medications prescribed, the following information must be noted in the clinical record:</p> <ul style="list-style-type: none"> • The nature of the member’s mental condition • 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including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff. • The reasonable alternative treatments available • The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications. • The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular member.

	<ul style="list-style-type: none"> • 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. • A notation that the member understands the nature and effect of medications and consents to administration of those medications. <p>Resource: 7-9-medication-consent-form-2023.pdf (acgov.org)</p>
Assessment & Medical Necessity	
<p>3. Required assessment is present and signed by staff with credentials to do so. If not present, reason for delay is noted.</p>	<ul style="list-style-type: none"> • The Mental Health Assessment includes information on all domains: <ul style="list-style-type: none"> ○ Domain 1- Presenting Problem(s)/Chief Complaint: Includes presenting problem and history of presenting problem(s), current mental status, member identified impairment(s) ○ Domain 2- Trauma: Includes trauma exposure, trauma reactions, trauma screening and system involvement. ○ Domain 3- Behavioral Health History/Co-occurring Substance Use ○ Domain 4- Medical History/ Current Medications/Co-occurring Conditions: Includes medical history, current medications, co-occurring conditions (other than substance use) ○ Domain 5- Social and Life Circumstances/Culture/Religion/Spirituality: Includes social and life circumstances, culture/religion/spirituality considerations ○ Domain 6- Strengths, Risk Behaviors, and Protective Factors: Includes risk factors and safety planning ○ Domain 7- Clinical Summary and Recommendations/ Diagnostic Impression Medical Necessity Determination/ Level of Care/Access Criteria: Includes diagnostic impression, treatment recommendations • The assessment includes: <ul style="list-style-type: none"> ○ Recommendations for medically necessary services and additional provider referrals, as clinically appropriate. ○ A typed or legibly printed name, signature of a Registered, waived or licensed service provider, provider title (or credentials), and date of signature. ○ Required co-signatures based on scope of practice. • The assessment is updated when new information is available that is likely to change the treatment or services provided.
<p>4. The member’s physical limitations, cultural and communication needs, or lack thereof, are noted.</p>	<ul style="list-style-type: none"> • Psychosocial factors are noted on the assessment or elsewhere in the chart, including information about the member’s physical, cultural and communication needs, or lack thereof.

<p>5. Documentation of coordination of care is present, anywhere in the chart, as clinically appropriate.</p>	<ul style="list-style-type: none"> • It is evident from the assessment and/or progress notes that efforts are being made to coordinate care with other providers as clinically appropriate. • Examples include the presence of Releases of Information forms authorizing communication with other service providers and/or documented efforts to communicate with other providers.
<p>6. CANS is finalized and signed on time (with all sections completed) by staff with the credentials to do so.</p>	<ul style="list-style-type: none"> • All members ages 0 up to 20 years old must have a CANS completed at opening, every 6 months and at discharge. • Two CANS tools are used in Alameda County: IP CANS and Birth-24 CANS. Birth-24 CANS includes all IP CANS questions plus additional questions for ages 0 up to 6 years old and other areas of need. Providers have the choice to complete either tool. • CANS must be administered by a CANS certified provider. <p>Reference: BHIN 25-035</p>
<p>7. PSC-35 is present for members ages 3 up to 18 years old, or documentation of parent refusal/lack of response is in chart.</p>	<ul style="list-style-type: none"> • The Pediatric Symptom Checklist (PSC-35) must be completed by day 60 of Episode Opening, every 6 months and at discharge for members ages 3 up to 18 years old. • If not completed, there should be documentation of refusal or lack of response.
<p>8. MH diagnosis or suspected diagnosis (includes Z codes) is present. If suspected or Z code is used, notes indicate efforts to clarify the diagnosis.</p>	<ul style="list-style-type: none"> • A Mental Health diagnosis is an important component of providing targeted, appropriate services. • The established diagnosis is supported by the clinical notes. • 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 experiencing homelessness. • In above situations, the following options can be used: <ul style="list-style-type: none"> ○ ICD-10 codes Z55-Z65 may be used by all providers, including an MHRS or other qualified staff. ○ ICD-10 code Z03.89, “Encounter for observation for other suspected diseases and conditions ruled out,” may be used by LMHPs. ○ In cases where services are provided due to a suspected disorder that has not yet been diagnosed, LMHPs may use any clinically appropriate ICD-10 code. For example, codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.” • If a Z code is used, it should be clear why a diagnosis was not made and what efforts are being made to establish a diagnosis. For example, are medical records being requested from other providers, collateral sessions being scheduled with the family or school to gather more historical information, etc. <p>Reference: BHIN 22-013</p>

<p>9. Meets Access Criteria and/or Medical Necessity</p>	<ul style="list-style-type: none"> • This is a Disallowance Reason • Documentation in the medical record must demonstrate that the member meets access criteria • <u>Access Criteria (Persons Under 21 years of age)</u>: The member has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: <ul style="list-style-type: none"> ○ Scoring in the high-risk range under a trauma screening tool approved by the department (see BHIN 26-002 AC Enclosure 1), involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. OR ○ The member has at least one of the following: <ul style="list-style-type: none"> • A significant impairment • A reasonable probability of significant deterioration in an important area of life functioning • A reasonable probability of not progressing developmentally as appropriate • A need for SMHS, regardless of presence of impairment, that is not included within the mental health benefits that a Medi-Cal Managed Care Plan (MCP) is required to provide. <p>AND</p> <p>The member’s condition as described in subparagraph (2) above is due to a diagnosed mental health disorder, OR a suspected mental health disorder that has not yet been diagnosed, OR significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.</p> <ul style="list-style-type: none"> • <u>Access Criteria (Persons over 21 years of age)</u>: The person has significant impairment, where impairment is defined as distress, disability or dysfunction in social, occupational, or other important life activities AND/OR there is reasonable probability of significant deterioration in important area of life functioning, AND the member’s condition is due to a diagnosed OR suspected mental health disorder, that has not yet been diagnosed. • <u>Medical Necessity (Persons age 21 and older)</u>: Pursuant to W&I Code section 14184.402(a), a service is “medically necessary” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in W&I Code section 14059.5. • <u>Medical Necessity (Persons under age 21)</u>: A service is “medically necessary” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as incorporated in subdivision(b)(1) of W&I Code section 14059.5. <p>Furthermore, federal guidance from the Centers for Medicare &</p>
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	<p>Medicaid Services (CMS) makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make a mental health condition more tolerable are considered to ameliorate the mental health condition, and are thus medically necessary and covered as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.</p> <p>Reference: BHIN 26-002</p>
<p>10. If risk occurred in the past 90 days, there is a comprehensive risk assessment and safety plan.</p>	<ul style="list-style-type: none"> • Risk refers to danger to self, danger to others or any other behaviors that might create risk of harm to the member or others. • A comprehensive risk assessment and safety plan should be in the chart and reviewed with member <i>initially</i> and <i>ongoing</i> when risk is present.
Problem List	
<p>11. A Problem List is present and supported by the documentation in the chart.</p>	<ul style="list-style-type: none"> • A Problem List should be started as soon as possible once the member is admitted. • The Problem List shall include, but is not limited to: <ul style="list-style-type: none"> ○ Diagnosis/es identified by a provider acting within their scope of practice. Diagnosis-specific specifiers from the current DSM shall be included, when applicable. ○ Current International Classification of Diseases (ICD) Clinical Modification (CM) codes. ○ Problems identified by a provider acting within their scope of practice. ○ Problems identified by the member and/or significant support person. ○ The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved. • The Problem List shall be updated on an ongoing basis, within a reasonable time, to reflect the current presentation of the member. • Providers, within their scopes of practice, shall add to, amend, or resolve problems from the Problem List when there is a relevant change to a member’s condition. • End dates are added only when problems are resolved or deferred. • In Clinician’s Gateway (CG), the Archive option is only used if a problem is added to the chart in error. • Problem Lists shall be standalone documents, separate from the Assessment and Progress Notes.

Progress Notes (spot check 3-5)	
<p>12. 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.</p>	<ul style="list-style-type: none"> • This is a DHCS Disallowance Reason • This item can be removed from the CQRT Checklist or marked as N/A if the agency’s Electronic Health Record automatically captures and ensures appropriate scope of practice for each service. The Electronic Health Record Attestation Form, in section 8 of the QA Manual, must be completed and provided to ACBHD prior to removing this item from the checklist. Completed Attestations must be kept for your records and sent to ACBHD, along with your CQRT Tracking Tool and/or completed CQRT Checklists when requested. • Resource: Scope of Practice in Section 13 of QA Manual
<p>13. Progress Note describes how interventions address member’s 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.</p>	<ul style="list-style-type: none"> • Progress Notes for all non-group services shall include: <ul style="list-style-type: none"> ○ The type of service rendered. ○ The date the service was provided to the member. ○ Duration of direct patient care for the service. ○ Location/place of service. ○ A typed or legibly printed name, signature of the service provider, and date of signature. ○ A brief description of how the service addressed the member’s behavioral health needs. ○ Brief summary of next steps. • Non- reimbursable services include the following: <ul style="list-style-type: none"> ○ Academic educational service ○ Vocational service that has work or work training as its actual purpose. ○ Socialization/Recreation ○ Transportation (e.g. transporting clients) ○ Clerical activities. Some examples include faxing, copying, leaving, or listening to voicemails, reading or writing emails, scheduling appointments, filling out SSI forms with or for the client, completing CPS or APS reports, writing court reports or letters, documenting a supervision note in the member’s chart. ○ Payee Related (e.g. purchasing items for a client) ○ Purely work-related activities (e.g. weekly supervision, trainings) ○ Missed appointments ○ Any activity that occurs after the client is deceased, including services provided to family members of deceased ○ Time spent driving in order to locate a client (e.g., locating a client who is currently homeless)

<p>14. Progress Note(s) for services rendered by multiple providers, either to a single member or a group, include all required elements.</p>	<p>For group services:</p> <ul style="list-style-type: none"> • The note should include the required elements of Progress Notes plus: <ul style="list-style-type: none"> ○ Describe the name and purpose of the group. ○ Identify the provider(s) that facilitated the group. ○ Include a brief description of the member’s response to the service. • Every participant must have a progress note in their clinical record. • A list of all group participants must be maintained by the provider outside the medical record. <p>If more than one provider rendered a service (either to a single member or to a group):</p> <ul style="list-style-type: none"> • At least one progress note per member must be completed and signed by at least one of the providers. • It is permitted for each provider to document a separate progress note. • The note(s) should clearly document: <ul style="list-style-type: none"> ○ Specific involvement and interventions of each provider. ○ Time involved in delivering the service for each provider (including travel and documentation). <p>Reference: BHIN 23-068</p>
<p>15. For Case Management services, there is a Care Plan present in a Progress Note.</p>	<p>Per CalMHSA Documentation Guide, the Care Plan must be in narrative form and include the following required elements:</p> <ul style="list-style-type: none"> • Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by member. • Includes activities such as ensuring the active participation of the member and working with them or their authorized health care decision maker and others to develop those goals. • Identifies a course of action to respond to the assessed needs of the member • Includes development of a transition plan when the member has achieved the goals of the care plan.

Revision History

Date	Responsible Person	Details
4/1/26	Torfeh Rejali, QA Division Director	Updated Informed Materials section to match new required timeframes, added minor consent requirements and primary language considerations.
4/1/26	Torfeh Rejali, QA Division Director	Added detailed information regarding the Medi-Cal requirements in the following sections: Assessment, Problem List, Progress Notes (group and individual services), Access Criteria and Medical Necessity BHIN 26-002
4/1/26	Torfeh Rejali, QA Division Director	Updated CANS and PSC-35 sections
4/1/26	Torfeh Rejali, QA Division Director	Added “ongoing” on #10 Risk assessment and plans

4/1/26	Torfeh Rejali, QA Division Director	Updated #13 with Progress Note requirements for non-group services and non-reimbursable services.
4/1/26	Torfeh Rejali, QA Division Director	Updated #14 to match the CQRT checklist. Clarified requirements for Progress Note(s) for services rendered by multiple providers and group services.
11/14/23	Amy Saucier, QA Clinical Review Specialist Supervisor	Updated Medication Consent requirements. Removed requirement for completion of ANSA