|  |
| --- |
| Complete all of the following: |
| 1. CQRT Date: |   | 5. Reporting Unit: |   |  |
| 2. Client Name: |   | 6. Primary: |   |  |
| 3. Client InSyst #: |   | 7. Episode Opening Date:  |   |  |
| 4. Provider Name: |   | 8. SUD Program Type: |   |  |
|  |  |  |  |  |
| 9. **OS/IOS Substance Use Disorder Services request** as indicated on treatment plan (check all that apply): |
| [ ]  Individual Counseling | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Group Counseling | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Medication Services | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Family Therapy (LPHAs Only) | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Collateral Services | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Patient Education (Grp/Ind) | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Group Multi-Family Counseling - ADOL | Frequency: |   | and As Needed  | Duration: |   |  |
|  |  |  |  |  |  |  |
| **Withdrawal Management Services request** as indicated on treatment plan (check all that apply) |  |
| [ ]  Observation | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Medication Services | Frequency: |   | and As Needed  | Duration: |   |  |
|  |  |  |  |  |  |  |
| **Recovery Support Services request** as indicated on treatment plan (check all that apply) |  |
| [ ]  Individual Counseling | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Group Counseling | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Recovery Service Monitoring/SAA | Frequency: |   | and As Needed  | Duration: |   |  |
|  |  |  |  |  |  |  |
| 10. **Case Management Services request** as indicated on treatment plan (check all that apply) |  |
| [ ]  Case Management: Care Coordination | Frequency: |   | and As Needed  | Duration: |   |  |
| [ ]  Case Management: Service Coordination | Frequency: |   | and As Needed  | Duration: |   |  |
|  |  |  |  |  |  |  |
| 11. **Medical Necessity** (both required for medical necessity): |
| [ ]  | Included SUD Diagnosis with individualized written basis (LPHA completing the diagnosis and written basis must meet face-to-face or via telehealth with beneficiary or SUD counselor who completed the assessment. Unlicensed LPHAs must have licensed LPHA co-signature) |
| [ ]  | ASAM Level of Care (ALOC). May be completed by SUD counselor or LPHA. Differences in LOC and placement must have clinical explanation. |
| 12. Primary Counselor/LPHA: |  | Recommend Approval: [ ]  Yes [ ]  No |
|  | Signature/Credentials |  |
| 13. Agency Supervisor:  |  | Recommend Approval: [ ]  Yes [ ]  Pending (30 Day Return) [ ]  No |
|  | Signature/Credentials |  |
| 14. CQRT Reviewer **(REQUIRED):** |   | Recommend Approval: [ ]  Yes [ ]  Pending (30 Day Return) [ ]  No |
|  | Printed Name |  |
|  |  |  |   |  |
|  | Signature/Credentials (LPHA or Certified SUD Counselor) |  | Date |  |
| 15. CQRT Chair **(REQUIRED):** [ ]  Full Authorization–Start Date: |   | End Date: |   |  |
| Returns: [ ]  Authorization pending return in 30 Days, by this date: |   |  |
| [ ]  No Authorization for DMC-ODS Services, chart to be returned to CQRT, by this date: |   |  |
| CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period).  |
|  |  |  |   |  |   |  |
|  | CQRT Chair Signature (Must be Licensed LPHA) |  | InSyst ID |  | Date |  |

|  |
| --- |
| **Use this Addendum if Chart is to be returned** |
| **1st Return** |
| Primary Counselor/LPHA Comments:  | Supervisor Comments:  |
| Primary LPHA/Counselor: |  | Recommend Approval: [ ]  Yes [ ]  No |
|  | Signature/Credentials |  |
| Agency Supervisor:  |  | Recommend Approval: [ ]  Yes [ ]  Pending (30 Day Return) [ ]  No |
|  |  |  |
| CQRT Reviewer or Chair Comments:  |
| CQRT Reviewer: |  | Recommend Approval: [ ]  Yes [ ]  Pending (30 Day Return) [ ]  No |
|  | Signature/Credentials (must be a Licensed, Registered or Waivered LPHA) |
| CQRT Chair: [ ]  Full Authorization–Start Date: |   | End Date: |   |  |
| Returns: [ ]  Authorization pending return in 30 Days, by this date: |   |  |
| [ ]  No Authorization for SUD DMC-ODS Services – Chart to be returned to CQRT, by this date: |   |  |
| CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period). |
|  |  |  |   |  |   |  |
|  | CQRT Chair Signature/License: |  | InSyst ID |  | Date |  |
| **2nd Return** |
| Primary Counselor/LPHA Comments:  | Supervisor Comments:  |
| Primary LPHA/Counselor |  | Recommend Approval: [ ]  Yes [ ]  No |
|  | Signature/Credentials |  |
| Agency Supervisor:  |  | Recommend Approval: [ ]  Yes [ ]  Pending (30 Day Return) [ ]  No |
|  |  |  |
| CQRT Reviewer or Chair Comments:  |
| CQRT Reviewer: |  | Recommend Approval: [ ]  Yes [ ]  Pending (30 Day Return) [ ]  No |
|  | Signature/Credentials (must be a Licensed, Registered or Waivered LPHA) |
| CQRT Chair: [ ]  Full Authorization–Start Date: |   | End Date: |   |  |
| Returns: [ ]  Authorization pending return in 30 Days, by this date: |   |  |
| [ ]  No Authorization for SUD DMC-ODS Services – Chart to be returned to CQRT, by this date: |   |  |
| CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period). |
|  |  |  |   |  |   |  |
|  | CQRT Chair Signature/License: |  | InSyst ID |  | Date |  |