



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.  At risk for out of home placement or change in placement.  
 Suicidal/homicidal ideation or acts.  Severe school and social impairment due to mental disorder.  
 Psychotic symptoms.

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  At risk for out of home placement or change in placement  
 Suicidal/homicidal ideation or acts  Severe school and social impairment due to a mental disorder  
 Severe or psychotic symptoms  Other (specify) \_\_\_\_\_

Committee Comments:

Provisional Authorization:  Yes  No

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

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

Committee Chair:

Signature and Staff Number

Reviewer:

Signature and Staff Number

Approval Date:

Review Date:

**QUALITY REVIEW - Regulatory Compliance**

<b>Medical Necessity:</b>				Yes	No	N/A	<b>Treatment Plan:</b>			Yes	No	N/A
<b>Five Axes DSM-IV included Diagnosis for Specialty Mental Health Services</b>							1. Initial Treatment or Service Plan completed by 30 days of opening episode date.					
<b>Impairment Criteria:</b> <i>Must have one of the following as a result of diagnosis:</i>							2. Treatment Plan reviewed every 6 months from opening episode date, updated or revised every 6 months and rewritten annually.					
1. A significant impairment in an important area of life functioning, <u>or</u>							3. There is a revised Treatment or Service Plan when there was a significant change in plan, service, diagnosis, problem, or focus of treatment.					
2. A probability of significant deterioration in an important area of life functioning, <u>or</u>							4. Treatment Plan includes objectives and planned interventions addressing identified impairments and strengths.					
3. A probability that the child will not progress developmentally as individually appropriate.							5. Objectives are measurable.					
4. Children covered under EPSDT qualify if they have a mental disorder, which can be corrected or ameliorated. (Current DHS EPSDT regulations apply.)							6. Treatment Plan Review (TPR) or Service Plan (SP) is signed and dated by LPHA.					
<b>Intervention Criteria:</b> Must have 1, 2, and 3							7. Treatment Plan Review signed and dated by MD, if the provider prescribes the medication.					
1. The focus of proposed intervention is to address the condition identified in the Impairment Criteria, <u>and</u>							8. Treatment Plan Review signed and dated by client/family/guardian.					
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, <u>and/or</u>							<b>Progress Notes:</b>					
2A. It is probable the child will progress developmentally as individually appropriate, <u>or</u>							Progress Notes are related to the TPR/SP's goals and objectives.					
2B. If covered by EPSDT can be corrected or ameliorated, <u>and</u>							<b>Mental Health Services:</b>					
3. The condition would not be responsive to physical health care-based treatment.							1. All Progress Notes are signed and dated with title.					
<b>Service Necessity:</b>							2. Procedure, location, date, and amount of time documented.					
1. What is the risk of the client's level of dysfunction increasing if fewer services were provided?							<b>Intensive Day Treatment/Crisis Residential:</b>					
Low 1 2 3 4 5 High							1. Daily Progress Notes are signed/co-signed and dated by LPHA or LVN, PT, or MHRS.					
2. Can a different type/level of <u>Speciality Mental Health Services</u> meet this client's need for services reasonably well?							2. Weekly summaries are signed/cosigned and dated by LPHA.					
3. Can a <u>primary care physician</u> or <u>private practitioner/therapist</u> meet this client's need for services (a lower level of care) reasonably well?							4. Placement Authorization is in chart for all Episodes opened after July 1, 2003.					
<b>Evaluation and Consent:</b>							<b>Rehabilitative Day Treatment/Residential:</b>					
1. Prenatal, perinatal and comprehensive developmental history is present.							1. Weekly summaries are signed/co-signed and dated by LPHA or LVN, PT or MHRS.					
2. Annual Community Functioning Evaluation or Youth Performance Outcome Measures are present.							2. Each date of service is identified in Progress Note.					
							3. Placement Authorization is in chart for all Episodes opened after July 1, 2003.					
							<b>Special Needs:</b>					
3. HIPAA Privacy Notice provided.							1. The client's cultural and linguistic needs are documented.					
4. Freedom of Choice is documented.							2. Information is provided to a client with visual and hearing impairments, if applicable.					
5. Beneficiary Problem Resolution form is present.							<b>Therapeutic Behavioral Services (TBS)</b>					
<b>Legibility:</b>							TBS services are documented in the TP, if applicable.					
Writing and signatures are legible.												

