



ADULT MENTAL HEALTH SERVICES Clinical/Quality Review

v. (1/3/15)

Complete the following:

- 1. Date:
2. Client Name:
3. Client Insyst #:
4. Provider Name:
5. Reporting Upit:
6. Clinician:
7. Episode Opening Date:
8. Authorization Cycle:

Request for (check all that apply):

9. Mental Health Services:

- Individual Psychotherapy, Individual Rehabilitation, Medication Services, Case Management/Brokerage, Family Psychotherapy, Group Services (Family Collateral Group, Multi-Family Therapy, Psychotherapy Group, Rehabilitation Group) with Frequency, As Needed, and Duration fields.

10. Day Treatment Services (check all that apply):

- Intensive: 5 Days/Week or Less, Exceeds 5 Days/Week, Initial 90 Days (3 months)
Rehabilitative: 5 Days/Week or Less, Exceeds 5 Days/Week, Initial 180 Days (6 months), Other

11. Discharge Readiness Criteria & Tentative Date:

Empty text box for discharge criteria and date.

12. Medical Necessity- (Medi-Cal Included Diagnosis; Support for Primary Diagnosis, Impairments to Functioning):

Empty text box for medical necessity details.

13. Focus of Treatment (Address Barriers to Lower Level of Care, Psychological issues, Risk (s) to Client or Others, Co-Occurring Issues etc.):

Empty text box for focus of treatment details.

14. List Proposed Interventions (i.e. CBT, M.I., If a Risk has been identified include how these will be assessed and contained.):

Empty text box for proposed interventions.

15. Agency Clinician: Recommended Approval: Yes No

Signature/Credentials

16. Agency Supervisor: Recommended Approval: Yes No

Signature/Credentials

17. CQRT Reviewer: Recommended Approval: Yes No (30 Day Return)

Signature/Credentials

18. Full Authorization - Start Date: End Date:

19. 30 Day Returns:

- 30 Day Authorization - Chart to be returned to CQRT:
No Authorization - Chart to be returned to CQRT:

20. CQRT Chair Comments:

Yellow highlighted area for CQRT chair comments.

21. Chart to be returned to CQRT - Date:

22. CQRT Chair Signature/Credentials: Date:

Provider Name & RU:

Medical Necessity	Yes	No	N/A
1. Primary diagnosis from CA- DHCS Medi-Cal Included Diagnosis List	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Documentation supports primary diagnosis (es) for treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Impairment Criteria: Must have one of the following as a result of dx</b>			
3A. Significant impairment in important area of life functioning, or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3B. Probable significant deterioration in an important area of life functioning, or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3C. Probable the child won't progress developmentally, as appropriate, or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3D. If EPSDT: MH condition can be corrected or ameliorated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Intervention Criteria: Must have: 4A and 4B, or 4C, or 4D	Yes	No	N/A
4A. Focus of proposed intervention: Address condition above, and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4B. Proposed intervention will diminish impairment/ prevent significant deterioration in important area of life functioning, and/or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4C. Allow child to progress developmentally as appropriate, or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4D. If EPSDT, condition can be corrected or ameliorated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Service Necessity: Must have both 5 and 6	Yes	No	N/A
5. The mental health condition could not be treated by a lower level of care? (true = yes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The mental health condition would not be responsive to physical health care treatment? (true=yes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Informing Materials:	Yes	No	N/A
7. Informing Materials signature page completed & is signed on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Releases of information, when applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Informed Consent for Medication(s), when applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special Needs:	Yes	No	N/A
10. Client's cultural/comm. needs noted or lack thereof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Client's cultural/communication needs addressed if identified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Client's physical limitations are noted or lack thereof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Client's physical limitations are addressed if identified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chart Maintenance	Yes	No	N/A
14. Writing is legible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Signatures are legible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Admission date is noted correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Filing is done appropriately.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Client identification is present on each page in the clinical record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Discharge/termination date noted, when applicable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Emergency info. is in a designated location in file/EHR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Med Order Sheet/Progress Note	Yes	No	N/A
21. Med Log updated at each visit, and with: (i.e. 4/8/10; Seroquel; 200mg; 1 po QHS; Marvin Gardens, MD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Drug name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Drug Strength/Size	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Instructions/ Frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Signatures/Initials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Assessment:	Yes	No	N/A
27. Initial Assessment done by 30 days of episode opening date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Annual Assessment completed on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Dx is established by licensed LPHA or co-signed by licensed LPHA for waived & registered staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Psychosocial history.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Presenting problems & relevant conditions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Risk(s) to client and/or others assessed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Client strengths/supports.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Hx of Psychiatric Medications prescribed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/adverse reactions/sensitivities or lack thereof			
35. Noted in chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/adverse reactions/sensitivities or lack thereof			
36. Noted prominently on chart's cover or in EHR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Relevant medical conditions/hx noted & updated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Mental health history.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Relevant mental status exam (MSE).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Past & Present Substance Exposure/Substance Use: Tobacco, Alcohol, Caffeine, CAM, Rx, OTC drugs, & illicit drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Youth: Pre/perinatal events & complete dev. hx.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Annual Community Functioning Evaluation (ACFE) N/A for FSP/Brief Service Programs & Level 3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Client Plan:	Yes	No	N/A
43. Initial Client Plan done by 60 days of episode opening date. (Level 3 by 4th visit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Annual Client Plan completed on time. (Applicable to charts on an Annual Authorization Cycle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Client Plan is consistent with diagnosis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Mental Health Objectives are specific, observable, and/or measurable with timeframes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Client Plan identifies proposed service modalities, their frequency and timeframes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Client Plan describes detailed provider interventions for each service modality listed in the Plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Client's Risk(s) have a safety plan (DTO, Harm to Self, at risk for DV, Abuse, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Plan signed/dated by LPHA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Plan signed/dated by MD, if provider prescribes MH Rx.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Coordination of care is evident, when applicable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Client Plan signed/dated by client or legal representative when appropriate or documentation of client refusal or unavailability.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Client Plan indicates client indicates the client/representative was offered a copy of the Client Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Client Plan contains Tentative Discharge Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Progress Notes:	Yes	No	N/A
57. There is a progress note for every service contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Correct CPT & Insyst service code	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Date of service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Location Listed & Correct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. Face-to-Face & Total times are documented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Notes for Ct encounters incl. that day's evaluation/ behavioral presentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Notes for Ct. encounters include that day's Staff Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. Notes for Ct. encounters incl. that day's Ct. response to Intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. Notes for Ct. encounters incl. Ct &/or Staff f/u plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66. Group service notes include # of clients in attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. Services are related to the current Client Plan's Mental Health objectives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. Unresolved issues from prior services addressed, if app.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. Signed & dated with designation: Licensed/Registered/Waivered/MHRS/Adjunct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. Completion line at signature (n/a for electronic notes).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71. Service provided while Ct. was not in lock-out setting, IMD, or Jail.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72. Service provided was NOT SOLELY for supervision, academic educational services, vocational services, recreation, and/or socialization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73. Service provided was NOT SOLELY transportation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
74. Service was NOT SOLELY clerical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75. Service was NOT SOLELY payee related	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76. Progress note was completed within the required timeframe per MHP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
77. Progress note documents the language that the service is provided in, as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
78. Progress note indicates interpreter services were used, and relationship to client is indicated, as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
79. E/M progress note is compliant with E/M documentation standards.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments/Feedback:

Reviewer:	Date:
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