Sacramento County Electronic Utilization Review Tool

EUR GENERAL TOOL

Member Name:	Member ID:	U.R. Date:
Provider and Program:		Reviewer Name:
Review Period:		Intake/First Medi-Cal Billable Service:
		Enrollment Date: Discharge Date (if applicable):

A	CSI: CLIENT INFORMATION (CLIENT)/ CSI STANDALONE COLLECTION / SPECIAL POPULATION/TIMELY ACCESS DATA TOOL						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
A1	Update CSI information	Expectation that all CSI information is completed (race, ethnicity, preferred language, etc.) within the CSI Standalone Collection (Client).					
A2	Special Populations Screen	Expectation that special populations associated with the member are documented within the Special Populations Screen. This screen gathers special populations such as: Foster Care, ICC/IHBS, Katie A, Presumptive Transfer, AOT, Probation, TFC, Homelessness, Housed.					
A3	TADT	Verify that the forms were completed: -MH-Non-Psychiatric SMHS Timeliness -MH Psychiatric SMHS Timeliness (if applicable)					

B	CLIENT CONTACTS: CLIENT INFORMATION (CLIENT) / COORDINATION OF CARE						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
B1	Family/ Significant Support Person(s)	Include the name of one family member/ significant support person(s), and their contact information (telephone number, etc.).					
B2	Professional Contacts	Include the name, address, and phone number of PCP/GMC or alternative healer.					
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C	SCANNING (MY OFFICE) /COLLATERAL INFORMATION						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
C1	Consent to Treat	Required at start of service.					
C1a	Informed Consent	Obtain new informed consent any time there is a substantial change in treatment. (This may be found within the consent to treat form.)					
C2	Telehealth Consent	If Telehealth or Telephone service(s) were provided: The health care provider must document in the patient record the provision of the following information and the patient's verbal or written acknowledgment that the information was received. a) The provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary: b) An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; c) An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi- Cal services in the future; d) An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the e) Potential limitations or risks related to receiving services through telehealth as compared to an in- person visit, to the extent any limitations or risks are identified by the provider.					

C3	Acknowledgement of Receipt	Required to be fully completed and signed by the member and legal or personal representative, if applicable, at start of services and annually thereafter, with all applicable boxes checked.					
C4	Accounting of Disclosure Form	Required, even if blank, and completed for unauthorized disclosures such as CPS/DCFAS. APS, State Audits, etc.					
C5	ROI's	ROI's must be completed in full with signatures and no blank fields; updated annually.					
C6	Informed Consent for Treatment with Psychotropic Medications	Look for a notation that informed consent to antipsychotic medications has been discussed with the member and that the member understands the nature and effect of antipsychotic medications, and consents to the administration of those medications or a JV-217 through JV-224 for each medication prescribed.					
C7	Completion of ICC/IHBS Screening	If applicable, all members under the age of 21 eligible for full scope Medi-Cal verify evidence of completion of ICC/IHBS screening determination (either ICC I HBS screening tool and/or documented on a service note.					
C8	Initial Intensive Care Coordination – Child and Family Team (ICC-CFT)	If applicable, verify that an ICC-CFT occurred within 60 days of eligibility determination.					
C9	ICC-CFT Timeliness	If applicable, verify that an ICC-CFT occurred every 90 days at minimum.					
C10	DHCS Transition of Care Tool	For clients who have been discharged and have a discharge reason of referred to one of the MCPs – Aetna, Anthem Blue Cross, Health Net, Molina, or Kaiser: Verify evidence that the statewide tool was used to make level of care decisions or delivery system decisions. Fax and scan into EHR. . Check NA for clients who are open or who are discharged to somewhere other than an MCP.					

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D	**DIAGNOSIS DOCUMENT (CLIENT)/ CLIENT CLINICAL PROBLEMS (CLIENT) (PROBLEM LIST)** **Diagnosis Date:**						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
D1	Access to SMHS	Verify if client has a CMS-approved ICD-10 diagnosis code.					
D2	Medical Necessity for SMHS	Post Assessment: Verify if client has an ICD 10 and a DSM 5 diagnosis.					
D3	Substance Use Disorder (SUD) Dx.	If a substance use diagnosis exists, it may be secondary to the primary mental health diagnosis.					
D4	ICD 10 and DSM 5 Updates	Verify that when clinically appropriate, the ICD 10 and a DSM 5 diagnosis has been updated as well as at discharge.					
D5	Problem List: Accurate	Problem List reflects the member's concerns, how long the issue has been present, and track the issue over time, including its resolution.					
D6	Problem List: Scope of Practice	Diagnoses/Problem identified by a provider acting within their scope of practice, if any. Include diagnostic specifiers from the DSM if applicable.					
D7	Problem List: Inclusive	Problems or illnesses identified by the member and/or significant support person, if any.					
D8	Problem List: Name and Title	The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.					
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E	CALAIM ASSESSMENT					Date completed:	
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
E1	Initial CalAIM Assessment	Verify that per best practice, the Initial CalAIM Assessment was finalized within 90 days of assignment to the provider, unless there is documentation of any issues (i.e., acuity, homelessness, difficulty with engagement) that prove to be a barrier to completion. Initial assessments are finalized as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards and best practice.					
E2	Update Assessment	Verify that per best practice, the Updated CalAIM Assessment was completed within the staff's clinical discretion (reasonable and in accordance with generally accepted standards of practice.) See CANS, PSC-35 and ANSA for documentation expectations for the updated assessment.					
E3	Domain #1: Description of current presenting reasons	Review the symptoms, behaviors, and impact of problem on person in care documented to support medical necessity. May include the duration, severity, context and cultural understanding of the problem(s). May include the onset of symptoms, severity and other significant changes affecting daily activities/functioning in important areas of life (history of presenting reasons).					
E4	Domain #1: Current Mental Status	Documentation of the members' current mental status at the time of the assessment. May include detailed observations regarding the member's appearance, speech, attitude, behavior, mood, and affect.					
E5	Domain #1: Beneficiary-Identified Impairment(s)	Documentation of level of impairment in functioning such as, level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning. Functioning should be considered in a variety of settings, including at home, in the					

		community, at school, at work and with friends or family.					
E6	Domain #2: Trauma Information	Documented assessment of traumatic incidents, the person in care's reactions to trauma exposures and the impact of trauma. Considered trauma exposures, trauma reactions, any information gathered from trauma screenings and system involvement. If relevant, assessment includes detailed information regarding history or exposure to trauma, including all trauma symptoms or behaviors, particularly if trauma is impacting current functioning.					
E7	Domain #3: Behavioral History	Detailed information describing mental health history, previous services including use of traditional or alternative healing practices and if applicable, inpatient services. May include time frames, length of treatment, efficacy/response to interventions, and how it benefited the member's life.					
E8	Domain #3: Comorbidity	Detailed information regarding history and/or current substance use issues including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.					
E9	Domain #4: Medical History and Physical Health Comorbidity	Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. If applicable: Information on allergies, including those to medications, should be clearly and prominently noted. If member is not yet linked to PCP/GMC/Alternative Healer, **confirm efforts made to link the client to a PCP/GMC/Alternative Healer** and, if warranted by medical condition, coordination of care documented in Service Notes.					
E10	Domain #4: Current Medications	Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications.					

		When available, the start and end dates or approximate time frames for medication should be included.					
E11	Domain #4: Developmental History	Primarily Ages 21 and Under: Prenatal and perinatal events and relevant or significant developmental history, if known and available.					
E12	Domain #5: Social and Life Circumstances	Documentation may include detail for family/ significant support person(s), functional, housing-living situation, school/work functioning, etc., to provide a complete history. May include documentation of daily activities, social supports/networks, legal/justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community.					
E13	Domain #5: Cultural Considerations	Verify that the member's cultural and language needs were explored, accommodated (e.g., the use of an interpreter) and documented. (Culture may include spirituality, religion, ethnic/racial background, sexual orientation, gender identity, language, ability/disability, acculturation, traditions, etc.)					
E14	Domain #6: Strengths	Documentation of personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships.					
E15	Domain #6: Risk Assessment	If identified past or present history of risky behaviors, detailed measures that were taken to ensure the member's safety and well-being should be documented. A completed Safety Plan should be documented. If there was a Safety Plan completed by the previous or concurrent provider, is there evidence of the most recent the Safety Plan reviewed by the current provider with the member to ensure current risks are addressed?					

E16	Domain #7: Clinical Summary and Recommendations	A clinical summary of symptoms supporting diagnosis, functional impairments, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list. Recommendations of specific interventions or service types or goals for care based on the clinical impression.					
E17	Domain #7: Diagnostic Impression	Diagnostic Impression may include clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified).					
E18	Domain #7: Medical Necessity Determination/Level of Care/Access Criteria	Documentation establishing Medical Necessity Determination/Level of Care/Access Criteria.					
COMMENTS							

F	**CHILD AND ADOLESCENT NEEDS AND STRENGTHS CANS (CHILD/YOUTH)** **CANS Date Completed:**						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
F1	Finalized CANS	(Ages 6-21) CANS is expected to be completed within the first assessment window, 6 months increments, and one month before discharge.					
F2	CANS and Treatment Services	CANS used to track changes/progress in treatment, inform services, and level of care. For significant changes, you may put this in the CalAIM Assessment Form and it must at minimum be documented in the service note.					
F3	CANS and Service Notes	Look for CANS information/reports to be used in sessions with member and/or caregiver to discuss changes in behaviors, symptoms, and progress toward. goals, treatment, and service activities. May also include changes to problem list or the care					

		plan within the service note based on CANS information.					
COMMENTS							

G	PEDIATRIC SYMPTOM CHECKLIST PSC-35 (CHILD/YOUTH)					PSC-35 Date Completed:	
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
G1	Finalized PSC-35	(Ages 3-18) PSC-35 is expected to be completed within the first assessment window, 6 months increments, and one month before discharge.					
G2	PSC-35 and Treatment Services	PSC-35 used to track changes/progress in treatment, inform services, and level of care. For significant changes, you may put this in the CalAIM Assessment Form and it must at minimum be documented in the service note.					
G3	PSC-35 and Service Notes	Look for PSC-35 information/outcomes to be used in sessions with member and/or caregiver to discuss changes in behaviors, symptoms, and progress toward goals, treatment, and service activities. May also include changes to problem list or the care plan within the service note based on PSC-35 information.					
COMMENTS							

H	ADULT NEEDS AND STRENGTHS ASSESSMENT ANSA (ADULT)					Date Completed:	
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
H1	Finalized ANSA	(Ages 21+) ANSA is expected to be completed within the first assessment window, 6 months increments, and one month before discharge.					

H2	ANSA and Treatment Services	Verify that the ANSA used to track changes/progress in treatment, inform services, and level of care. For significant changes, you may put this in the CalAIM Assessment Form and it must at minimum be documented in the service note.					
H3	ANSA and Service Notes	Look for ANSA information/reports to be used in sessions with member to discuss changes in behaviors, symptoms, and progress toward goals, treatment, and service activities. May also include changes to the problem list or care plan within the service note based on ANSA information.					
COMMENTS							

I	**CARE PLAN**					**Date Completed:**	
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
I1	Initial Care Plan	Verify that per best practice, the Initial Care Plan within the Service Note was finalized within 90 days of enrollment to the provider, unless there is documentation of any issues (i.e., acuity, homelessness, difficulty with engagement) that prove to be a barrier to completion. TCM, Peer Support Services, ICC Intensive Care Coordination (This may include the plan to provide other services as part of that ICC such as, IHBS or TFC), CRP, STRTP, TBS and FSP services are required in the Care Plan within the Service Note. Care Plans may include/combine more than one service, as long as those services are clinically covered and within the scope of practice of that staff. The only exceptions are based off of scope such as, Peer Services and Housing Plans which have specific requirements based on funds indicated,					

		frequency, duration, timelines and a sustainability plan.					
I2	Update / Care Plan	The Care Plan within the Service Note should be updated when there are significant changes in the member's mental health condition or may be updated anytime when needed. The time period to complete an updated Care Plan are up to clinical discretion (reasonable and in accordance with generally accepted standards of practice.)					
I3	Goals	Mental health treatment related goals must address the "reasons for service/problem." Include specific goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational, and other services needed by the beneficiary.					
I4	Interventions: Activities	Includes activities such as ensuring the active participation of the member and working with the member (or the member's authorized health care decision maker) and others to develop those goals.					
I5	Interventions: Course of Action	Identifies a course of action to respond to the assessed needs of the member.					
I6	Transition Plan	Include development of a transition plan when a beneficiary has achieved the goals of the care plan within the Service Note.					
I7	Staff's Signature on the service note containing the Care Plan	Verify that there is a qualified staff's electronic signature on the service note containing the care plan and electronic co-signature if required.					
I8	Collaboration of the Care Plan with member	Evidence speaking to collaboration such as, service note including that collaboration within the narrative or documenting that a copy of the Care Plan was offered, producing a Care Plan upon request.					
COMMENTS							

J	DOMAIN #4: INITIAL PSYCHIATRIC ASSESSMENT					Date Completed:	
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
J1	Initial Psychiatric Assessment	Initial Psychiatric Assessment within the service note must be finalized at start of psychiatric services if the client is receiving medication management services with the provider.					
J2	Chief Complaint	Presenting issues, relevant medical conditions, and risk factors must be documented.					
J3	Psych History	Past and current psychiatric history affecting the current mental health condition(s) must be documented. Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medications should be included. Information on allergies, including those to medications, should be clearly and prominently noted.					
J4	Psychiatric Mental Status Exam	Psychiatric MSE was documented within the service note at start of psychiatric services. Verify that per best practice, the Updated Psychiatric MSE was completed within the service note at the staff's clinical discretion (reasonable and in accordance with generally accepted standards of practice). If there are unknown areas, an explanation may be found in the progress notes. This does not apply to Crisis Residential.					
COMMENTS							

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K	FLOW SHEET (CLIENT) (VITALS)						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
K1	Flow Sheet (Client)	Preference: Vital signs are recorded in the "Flow Sheet (Client)" of the chart if the member is receiving medication management services with the provider. For EUR, defer to the clinical judgment of the Provider regarding recording Vitals within the Flow Sheet (Client).					
COMMENTS							

L	CLINICAL SERVICE NOTES						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
L1	Clinical Introductory Note	Written at first visit, or soon after, includes a brief summary of reason for services, access criteria/medical necessity, description of symptoms, behaviors, functional impairment, relevant cultural explanations and proposed plan.					
L2	Procedure Codes Billed	Documentation of service delivered must support procedure code that was claimed. Note: Disallowances will only be in line with Fraud, Waste and Abuse.					
L3	Service Notes Content and Accurate Picture	Service notes are unique and not "cookie cutter" or "copy/paste" including depicting an accurate picture of the person's condition, treatment provided and may include response to care at the time the service was provided.				.	
L4	Service Notes Content/Intervention	The intervention is appropriate to address the identified Problems. A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors) is required.					
L5	Service Notes Content/Plan	Service notes must include next steps including, but not limited to, planned action steps by the provider or by					

		the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate.					
L6	Service Notes Out of Scope	Verify that the intervention provided was within the scope of practice of the practitioner.					
L7	Service Notes Reflecting Quality	The following list are characteristics of a service note that supports quality documentation. Verify that Service Notes reflected the following characteristics: Clear, Reliable, Consistent, Accurate/Precise, Descriptive, Timely					
L8	Cultural Consideration	Member's cultural and language needs were explored, accommodated (e.g., the use of an interpreter) and documented.					
L9	Group Services	When a group service is rendered, a list of participants is required to be documented and maintained by the provider. The progress note for the group service encounter shall also include a brief description of the members' response to the service. If two staff facilitated the group, each staff's role must be distinct/unique and justified. Each staff member must complete a separate service note for the service.					
L10	Non-Billable Services	Appropriate documentation of non-billable services, such as supervision, researching a topic, interpretation services, filing, faxing, academic instruction services, transportation, etc.					
L11	Lockout Services	Appropriate documentation for services provided while the client was in a lockout situation, such as jail, juvenile hall, or psychiatric hospitalization					

L12	Service Notes that Need to be Amended or Disallowed	Please list the service notes that need to be amended (within 45 days from the date of service) or disallowed on the supplemental worksheet, including the date and procedure code of the service note and the reason for the disallowance. Please indicate if the service note needs to be appended or disallowed. **Provider must submit the supplemental worksheet with the corrected McFloops if "Reportable" is selected.** Selecting "Completed" means there are no service notes that need to be amended or disallowed.					
L13	Service Note Timeliness	Verify that service notes were completed within **three business days** of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0).					
L14	Service Notes indicate Warm Hand-off Transfer/Coordination of Care prior to discharge (either MHP to MHP or MHP to MCP.)	If applicable, when the member is discharging and/or transferring service providers (within MHP or to the MCP) did the current service provider conduct a warm hand-off transfer with the receiving service provider to obtain initial appointment? Documentation within the Service Note should include who is the receiving service provider and the 1st appointment date and time and any additional relevant information.					
COMMENTS							

M	**MEDICATION SERVICES SERVICE NOTES**						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
M1	Procedure Codes Billed	Verify that each procedure code billed matches the service delivered. Including psychotherapy add on justification if applicable.					

M2	Group Session	Look for group type, topic, goal, staff intervention, member participation and response (unique to each individual member's mental health condition) as well as follow-up plan. Also, if two staff facilitated the group, each staff's role should be distinct/unique and justified. Each staff member must complete a separate service note for the service.					
M3	Excessive Billing	Billing for administrative type duties (e.g. faxing and making copies) with no specific medication service function. Time for no-shows with no service of benefit to the member may not be claimed.					
COMMENTS							

N	**GENERAL DOCUMENTATION**						
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
N1	HIPAA	Guidelines were adhered to (no breaches of confidentiality, such as other person's info in member's chart, etc.)					
N2	Medical Necessity	Verify that the overall documentation in the chart justifies medical necessity.					
COMMENTS							

Overall strengths found within the chart Examples to consider: • What worked well within the treatment? • What did the member achieve in treatment? • What were the improvements to goals? • What positive supports were provided by mental health staff? • What linkages to natural supports and resources occurred?	

• What coordination with other system partners occurred? • Was there consistent communication amongst the team? • What positive interventions did Treatment Team provide?	