# MENTAL HEALTH URGENT CARE CLINIC ELECTRONIC UTILIZATION REVIEW TOOL

|  |  |  |
| --- | --- | --- |
| Member Name: Click or tap here to enter text. | Member ID: Click or tap here to enter text. | U.R. Date: Click or tap here to enter text. |
| Provider and Program: Mental Health Urgent Care Clinic  | Reviewer Name: Click or tap here to enter text. |
| Review Period: Click or tap here to enter text. | Enrollment Date: Click or tap here to enter text. |

|  |  |
| --- | --- |
| **A** | **CSI: CLIENT INFORMATION (CLIENT)/CSI STANDALONE COLLECTION/SPECIAL POPULATION** |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| A1 | Update CSI information (CSI Standalone Collection and Client Information screens) | Expectation that all CSI information is completed (race, ethnicity, preferred language, etc.). |[ ] [ ] [ ]   |  |
| 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, etc.  |[ ] [ ] [ ]   |  |

|  |  |
| --- | --- |
| **B** | **CLIENT CONTACTS: CLIENT INFORMATION (CLIENT)/ COORDINATION OF CARE**  |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| B1 | Family/Support person | Include the name of one family member/support person, and their contact information (telephone number, etc.).  |[ ] [ ] [ ]   |  |
| B2 | Professional Contacts | Include the name, address, and phone number of PCP/GMC or alternative healer |[ ] [ ] [ ]   |  |
| COMMENTS |  |

|  |  |
| --- | --- |
| **C** | **INTAKE** |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| C1 | Consent to Treat  | Required at start of service and is part of the intake packet. Verify that the Consent to Treat was signed by the member and/or if applicable, legal representative.  |[ ] [ ] [ ]   |  |
| C2 | 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. |[ ] [ ] [ ]   |  |
| C3 | Accounting of Disclosure | Required, even if blank, and completed for unauthorized disclosures such as CPS. APS, State Audits, etc. |[ ] [ ] [ ]   |  |
| C4 | ROI’s | ROI’s must be completed in full with signatures and no blank fields; updated annually. (ROI’s must be completed in all circumstances beyond what is outlined in the notice of privacy practices signed by beneficiary and/or if applicable, legal representative.)  |[ ] [ ] [ ]   |  |
| C5 | Client Information Screen | Verify admission form includes: accurate spelling of the member’s name and date of birth. |[ ] [ ] [ ]   |  |
| C6 | Financial Information Form | Verify the Financial Information Form (FIF) is scanned into SmartCare in the non-episodic episode. |[ ] [ ] [ ]   |  |
| C7 | Medi-Cal Insurance | Was Medi-Cal insurance run?  |[ ] [ ] [ ]   |  |
| C8 | ID/ Insurance  | Verify copies of ID/Insurance cards are scanned in SmartCare. |[ ] [ ] [ ]   |  |
| COMMENTS |  |

|  |  |
| --- | --- |
| **D** | **DIAGNOSIS/PROBLEM LIST Diagnosis Date:** Click or tap here to enter text. |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| D1 | Access to SMHS | Verify if member has a CMS-approved ICD-10 diagnosis code.  |[ ] [ ] [ ]   |  |
| D2 | 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.  |[ ] [ ] [ ]   |  |
| D3 | Substance Use Disorder (SUD) Dx. | If a substance use diagnosis exists, it must be secondary to the primary mental health diagnosis. |[ ] [ ] [ ]   |  |
| D4 | 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. |[ ] [ ] [ ]   |  |
| D5 | 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.  |[ ] [ ] [ ]   |  |
| D6 | Problem List: Inclusive | Problems or illnesses identified by the member and/or significant support person, if any. |[ ] [ ] [ ]   |  |
| D7 | 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. |[ ] [ ] [ ]   |  |
| COMMENTS |  |

|  |  |
| --- | --- |
| **E** | **SCREENING**  |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| E1 | Self-Report Checklist | Verify that the Self-Report Checklist is complete and scanned into the client’s record. |[ ] [ ] [ ]   |  |
| E2 | Self-Report Checklist | Verify that the Name/SmartCare ID are on both sides of Self-Report Checklist |[ ] [ ] [ ]   |  |
| E3 | Self-Report Checklist Risk  | If Orange Box Risk is indicated then verify that the following occurred: Urgent Physical / Medical Conditions requires urgent prescriber assessment. If no prescriber was available, the individual has proceeded to the ER or prescriber may have determined that the individual should proceed to the ER.. |[ ] [ ] [ ]   |  |
| E4 | Self-Report Checklist Risk | If Green Box Risk is indicated then verify that the following occurred: Physical / Medical Conditions requires review by a prescriber or nurse. If no prescriber was available, the individual has proceeded to their PCP or Medical Urgent Care or prescriber may have determined that the individual should proceed to PCP or Medical Urgent Care. |[ ] [ ] [ ]   |  |
| E5 | Self-Report Checklist Risk | If Blue Box Risk is indicated then verify that the following occurred: This is a Psychiatric Evaluation Question. Member must have been seen by a nurse, prescriber or clinician to evaluate for 5150 criteria. |[ ] [ ] [ ]   |  |
| E6 | Triage Outcome in Service Note | Verify that the Self-Report Crisis Triage Outcome was completed within the Service note and includes LPHA and Medical Staff Template in the Service Note and the Disposition documented. |[ ] [ ] [ ]   |  |
| E7 | Triage Outcome Disposition in the Service Note |  Did the disposition selected match the identified documented need in accordance with that LPHA oversight and guidance.  |[ ] [ ] [ ]   |  |
| E8 | Vitals | Verify that vitals have been entered into the “Enter vitals” screen in SmartCare.  |[ ] [ ] [ ]   |  |
| COMMENTS  |  |

|  |  |
| --- | --- |
| **F** |  **CRISIS ASSESSMENT (CLIENT)                                                  Date completed:** Click or tap here to enter text. |
|   |   | Requirements  | Completed  | Reportable  | N/A  | Reviewer Comments  | Program Response  |
| F1  | Initial Crisis Assessment (Client)  | Expectation that the Crisis Assessment completed within timeframe expectations. See specific program requirements/contract requirements.   | [ ]  | [ ]  | [ ]  |   |   |
| F2  | Update Crisis Assessment (Client)  | Expectation that the Crisis Assessment updated when clinically indicated or in accordance with general clinical practices.  The time period to complete an updated Crisis Assessment are up to clinical discretion (reasonable and in accordance with generally accepted standards of practice.)  | [ ]  | [ ]  | [ ]  |   |   |
| F3  | Referral Source  | Expectation to document the referral source for linkage to crisis services.   | [ ]  | [ ]  | [ ]  |   |   |
| F4  | Presenting Problem  | Expectation of the member’s current mental health symptoms, behaviors, and emotions and the level of functional impairment observed or reported.   | [ ]  | [ ]  | [ ]  |   |   |
| F5  | Circumstances Leading to Current Crisis   | Expectation of documentation that includes the onset of symptoms, severity and other significant changes affecting daily activities/functioning in important areas of life (psychosocial stressors).  | [ ]  | [ ]  | [ ]  |   |   |
| F6  | Relevant History  | Expect relevant information regarding history or exposure to trauma, including all trauma symptoms or behaviors, particularly if trauma is impacting current functioning.  | [ ]  | [ ]  | [ ]  |   |   |
| F7  | Substance Use  | Detailed information regarding history and/or current substance use issues.  Recommended: If presently using, if history of use is clinically relevant or use impacts current functioning the Co-occurring Disorders Assessment (CODA) may be completed.  | [ ]  | [ ]  | [ ]  |   |   |
| F8  | Agencies/Programs Involved with Member  | Detailed information describing agencies and programs involved with the member, including time frames, and how those services benefited the member’s life.  | [ ]  | [ ]  | [ ]  |   |   |
| F9  | Current Psychotropic Medications and Prescriber   | Documentation may include detail for current psychotropic medications and prescriber. Details including any allergies or special precautions.   | [ ]  | [ ]  | [ ]  |   |   |
| F10  | Indicated Risk of DTS, DTO, GD  | Expect details about the member’s current risk for Danger to Self (DTS), Danger to Others (DTO), and/or Grave Disability (GD). Details including ideation, plan, access to means, lethality, prior attempt, intent/intended target.  | [ ]  | [ ]  | [ ]  |   |   |
| F11 | Documented consultation with LPHA in Risk Summary  | If Risk is identified and non-LPHA staff completes Crisis Assessment, verify there is a documented consultation with an LPHA in the Risk Summary section.  | [ ]  | [ ]  | [ ]  |   |   |
| F12 | Does the Member Meet Criteria for an Involuntary Hold?  | Expect details regarding the member’s criteria for an Involuntary Hold.   | [ ]  | [ ]  | [ ]  |   |   |
| F13 | Safety Plan/Next Steps  | 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.   | [ ]  | [ ]  | [ ]  |   |   |
| F14 | LPHA Co-Signature  | Open to all staff classifications, must be Co-Signed by an LPHA.   | [ ]  | [ ]  | [ ]  |   |   |
| COMMENTS   |    |

|  |  |
| --- | --- |
| **G** | **CRISIS SAFETY PLAN                                                                                             Date Completed:** Click or tap here to enter text. |
|   |   | Requirements  | Completed  | Reportable  | N/A  | Reviewer Comments  | Program Response  |
| G1  | Crisis Safety Plan  | If indicated is Crisis Safety Plan completed: Expect details of the identified risks, warning signs of a crisis, proactive/reactive strategies, support systems.   |  [ ]  |  [ ]  |  [ ]  |   |   |
| COMMENTS   |  |

|  |  |
| --- | --- |
| **H** | **COORDINATION OF CARE**  |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| H1 | Unlinked Members | If unlinked, are appropriate referrals being completed for outpatient psychiatric services? Are referrals documented? Evidence may include: Level of Care Screening Tool (LIST), Transition of Care Tool if referring to the MCP and documented in the service note.  |[ ] [ ] [ ]   |  |
| H2 | Unlinked Members | If unlinked and eligible for the Mental Health Plan (MHP), was a service request completed correctly and on the day of service? Mark reportable if the service request was not completed correctly or if it was submitted past the third day of service.  |[ ] [ ] [ ]   |  |
| H3 | Linked Members | If linked, has appropriate coordination of care been provided and documented?  |[ ] [ ] [ ]   |  |
| COMMENTS |  |

|  |  |
| --- | --- |
| **I** | **CLINICAL SERVICE NOTES** |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| I1 | Procedure codes Billed | Documentation of service delivered must support service code that was claimed. Note: Disallowances will only be in line with Fraud, Waste and Abuse. |[ ] [ ] [ ]   |  |
| I2 | Service notes Content/Medical Necessity | Service notes are unique and not “cookie cutter,” establishing medical necessity for the service by addressing member’s Sx/Bx/functional impairment.  |[ ] [ ] [ ]   |  |
| I3 | Service notes Content | Service notes include a summary of the services provided.  |[ ] [ ] [ ]   |  |
| I4 | Service notes Out of Scope | Verify that the intervention provided was within the scope of practice of the practitioner. |[ ] [ ] [ ]   |  |
| I5 | Service notes Content/Plan | Service notes contain a relevant follow up plan. |[ ] [ ] [ ]   |  |
| I6 | Cultural Competence | Member’s cultural and language needs were explored, accommodated (e.g., the use of an interpreter) and documented |[ ] [ ] [ ]   |  |
| I7 | Coordination of Care Services | Service notes must indicate coordination of care (intra and inter agency) as well as evidence of clinical case conferencing within the agency as medically necessary. |[ ] [ ] [ ]   |  |
| I8 | Excessive Billing | Documentation should support the amount of time that is billed.  |[ ] [ ] [ ]   |  |
| I9 | Duplicative Services | Duplicative services are not billed  |[ ] [ ] [ ]   |  |
| I10 | Non-Billable Services | Appropriate documentation of non-billable services, such as supervision, researching a topic, interpretation services, filing, faxing, academic instruction, transportation, etc. |[ ] [ ] [ ]   |  |
| I11 | Documented Discharge  | Verify that the discharge disposition service was documented and completed by a clinician for all services provided beyond Peer services. Peers may document the discharge disposition.  |[ ] [ ] [ ]   |  |
| I12 | Service notes that Need to be Amended or Disallowed  | Please list the Service notes that need to be amended or disallowed on the supplemental worksheet, including the date and billing code of the progress note and the reason for the disallowance. Please indicate if the progress 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 appended or disallowed. |[ ] [ ] [ ]   |  |
| I13 | Service Note Timeliness | Verify that Service notes are not currently in draft status **past 24 hours from the date of service**.  |[ ] [ ] [ ]   |  |
| COMMENTS |  |

|  |  |
| --- | --- |
| **J** | **MEDICATION SERVICES SERVICE NOTES** |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| J1 | Procedure codes Billed | Verify that each service code billed matches the service delivered. Including Psychotherapy with Patient an EM Service add on justification if applicable. |[ ] [ ] [ ]   |  |
| J2 | Excessive Billing | Billing for administrative type duties with no specific medication service function. Time for no-shows with no service of benefit to the member may not be claimed. |[ ] [ ] [ ]   |  |
| J3 | 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. |[ ] [ ] [ ]   |  |
| COMMENTS  |  |

|  |  |
| --- | --- |
| **K** | **DISCHARGE** |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| K1 | After Care Form | Was the After Care Form finalized (discharge plan documented) and scanned into the member’s record. |[ ] [ ] [ ]   |  |
| K2 | Length of Stay (LOS) | Verify that the member was discharged from the program within 3 days of admission.  |[ ] [ ] [ ]   |  |
| COMMENTS |  |

|  |  |
| --- | --- |
| **L** | **GENERAL DOCUMENTATION** |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| L1 | HIPAA  | Guidelines were adhered to (no breaches of confidentiality, such as other person’s info in member’s chart, etc.). |[ ] [ ] [ ]   |  |
| L2 | 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/service provision?
* What did the member achieve in treatment/service provision?
* 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/Team provide?
 |       |