



Substance Use Prevention and Treatment (SUPT) Electronic Utilization Review (EUR) Tool -Member Charts

EUR SPECIFIED FIELDS

Member Name:	Member ID:	U.R. Date:
Provider and Program:	Reviewer Name:	
Review Period:	Intake First Medi-Cal Billable Service:	
Mid-Year <input type="checkbox"/> Annual <input type="checkbox"/>	Enrollment Date:	Discharge Date (if applicable):
Funding: DMC-ODS <input type="checkbox"/> CalWORKs <input type="checkbox"/> Realignment <input type="checkbox"/> SUBG <input type="checkbox"/> SAMHSADT <input type="checkbox"/>	Level of Care:	

A							
CLIENT INFORMATION (CLIENT)/ SPECIAL POPULATION							
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
A1	Client Information	Expectation that all member information is completed within county EHR (name, DOB, ID number, address, telephone number, race, ethnicity, preferred language).					
A2	Special Population 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.					

B							
CLIENT CONTACTS: CLIENT INFORMATION (CLIENT) / COORDINATION OF CARE/EMERGENCY CONTACT							
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
B1	Family/Next of Kin/Emergency contact	Include the name of the contact, address, telephone number, etc. (Separate from the Emergency Contact ROI. Please see item number D8) This found within EHR in Client Information (Client)-Contacts Tab.					



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B2	Professional Contacts	Include the name, address, and phone number of PCP/GMC or alternative healer					
B3	Referral	Source and reason are documented in client record. (CA ASAM/, /Intake Service Note)					
COMMENTS							

C		CalOMS	Date Completed:				
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
C1	CalOMS Admission (Client)	Completed in EHR. Date: _____ (within 30 of enrollment).					
C2	CalOMS Annual Update	Completed in EHR. Date: _____ (within 11/12 month of services if applicable if client remains in treatment).					
C3	CalOMS StandAlone Update/Discharge/ (Client)	CalOMS Discharge completed in EHR within last 30 days of clinical contact., NTP—14 days from the last dose. Date: _____					
COMMENTS							

D SCAN DOCUMENT SECTION/COLLATERAL INFORMATION							
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response



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D1	Enrollment Agreement/Consent to Treat	Required at start of service.					
D1a	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).					
D1b	Consent to Follow-Up	Completed and signed at the start of services.					
D2	Telehealth Consent	<p>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.</p> <p>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 member;</p> <p>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;</p> <p>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 member without affecting their ability to access covered Medi- Cal services in the future;</p> <p>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</p> <p>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.</p>					



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D3	Medication Consent (MAT/NTP's)	Medication Consent Forms for MAT/NTP medication and services specific to the medication prescribed if applicable and authorizations (methadone, Naloxone, Benzodiazepine, injectables).					
D4	Provider Acknowledgement of Receipt	Required to be fully completed and signed by member and legal or personal representative, if applicable, at start of services and annually thereafter, with all applicable boxes checked.					
D5	Sacramento County 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. Completed and signed (Notice of Privacy Practices, Member Handbook, Grievance/State Fair Hearing, Advance Directive, and Provider Directory). Required to be fully completed and signed by the member and legal/personal representative, if applicable, at start of services and annually thereafter, with all applicable boxes checked.					
D6	Accounting of Disclosure Form	Required, even if blank, and completed for unauthorized disclosures such as CPS, APS, State Audits, etc.					
D7	ROI's	ROI's must be completed in full with signatures and no blank fields; updated annually.					
D8	ROI for Emergency Contact	Is documented in chart with the Expiration date:_____ and reason for decline in Service Note if not in chart.					
D9	Dual Enrollment/Multiple Registration (MAT/NTP's)	Dual Enrollment / Multiple Registration has been checked. With verification maintained in the member file.					



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D9a	Dual Enrollment/Multiple Registration for Transfer (MAT/NTP's)	If Dual Enrollment / Multiple Registration has not been checked, member is a transfer (from detox or from another clinic), or member tested negative (-) for methadone and methadone metabolite at intake.					
D10	DHCS Transition of Care Tool for MH services	For members 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 N/A for clients who are open or who are discharged to somewhere other than an MCP.					
COMMENTS							

E	DIAGNOSIS/CLIENT CLINICAL PROBLEM (CLIENT)			Diagnosis Date:			
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
E1	Access to SUD services	Verify if member has a CMS-approved ICD-10 diagnosis code.					
E2	Medical Necessity for SUD Services	Post Assessment: Verify if client has an ICD 10 and a DSM 5 diagnosis.					
E3	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.					
E4	Client Clinical Problem (Client): Accurate	Problem List reflects the member's concerns, how long the issue has been present, and tracks the issue over time, including its resolution.					



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E5	Client Clinical Problem (Client): 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.					
E6	Client Clinical Problem (Client): Inclusive	Problems or illnesses identified by the member and/or significant support person, if any.					
E7	Client Clinical Problem (Client): 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					
E8	Pregnancy Indicator	Medi-Cal requires providers to use a pregnancy indicator to specify when services are provided to a pregnant client. In the Client Clinical Problem Details (Client) screen use SNOMED Code. 248985009 (Z33.1) to indicate the client is pregnant. Note: Don't forget to add an end date when the client is no longer pregnant. [is the end date still the 365 days post birth? If so state that] Please note: NTP providers that bill perinatal are completing the Problem list for pregnant clients.					
COMMENTS							

F	INITIAL ASSESSMENT (CA ASAM)	Date completed:					
	Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response	
F1	Initial CA ASAM Assessment	Verify that per best practice, the Initial SUD was finalized within 30 (OS/IOS) 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 within					



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		60 days (28 days NTP, 10 days Residential, and WM areas deemed appropriate for urgent services (Dimension 1, COWS, CIWA for these urgent level of services) from the date of enrollment.					
F2	Update CA ASAM Assessment	Verify that per best practice, the Updated/Reassessment was completed within the staff's clinical discretion (reasonable and in accordance with generally accepted standards of practice, stepping client up or down in LOC. The update would be completed within the Service Note.					
F3	Dimension#1: Acute Intoxication and/or Withdrawal Potential	Describe reasons for seeking services in the client's own words. List of substances and indicate details of use (Date of last use, Duration of, Continuous Use, Frequency in the Last 30 Days, Route. Substance use history, any life-threatening withdrawal symptoms, and history.					
F4	Dimension#2: Biomedical Conditions and Complications	Physical health conditions - relevant current or past medical conditions, including treatment history, information on help seeking for physical health treatment, allergies (including those to medications). Medications - current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, efficacy/benefits, and if available, start/end dates or approximate timeframe., medical symptoms.					
F5	Dimension#3: Emotional, Behavioral, or	Mental health history, behaviors and symptoms, previous services, risk factors and behaviors, types of abuse or trauma experienced.					



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	Cognitive Conditions and Complications						
F6	Dimension#4: Readiness to Change Severity Rating	Role of substance use, motivation for treatment, assist (s) or barrier (s) to recovery					
F7	Dimension#5: Relapse, Continued Use or Continued Problem Potential	Describe the desire and urge to use, trigger(s) or stressor(s): indicate and describe what can contribute to Substance Use.					
F8	Dimension#6: Recovery/Living Environment	Current living environment, family history, current family involvement, significant life events within family, relationships that are supportive to stopping or reducing substance use, involved in any relationships that pose a threat, legal/justify involvement, military history, community engagement, interactions with others/relationship with their community, school, employment.					
F9	LOC/Severity Ratings	The indicated Level of Care (LOC) is supported by severity ratings in each CA ASAM/ Dimension.					
F10	Actual/Indicated LOC	The actual LOC is either the same as indicated by the CA ASAM/ Assessment or the different LOC is sufficiently justified.					
F11	Completion of CA ASAM by Classification	ASAM/SUD Assessment was completed by approved registered classification. (AOD Counselor, LPHA) Name: _____					
F12	Service Note Documenting CA ASAM	Service Note documenting completion of CA ASAM Assessment by approved registered classification. (AOD Counselor, LPHA) Date: _____					
F13	Consult Following the Assessment	Placement was supported/confirmed by an LPHA through a face-to-face, telehealth,					



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		phone consult (Care coordination). Date: _____					
F14	LPHA Medical Necessity	LPHA supported the basis for the diagnosis based on Medical Necessity and documented appropriately. Date: _____					
F15	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 religion, ethnic/racial background, sexual orientation, gender identity, language, ability/disability, acculturation, etc.) This can be included within the CA ASAM Assessment or Service Note.					
COMMENTS							

G	HEALTH QUESTIONNAIRE & PHYSICAL EXAM	Date Completed:					
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
G1	Initial Health Questionnaire	Verify that per best practice, the Initial Health Questionnaire (5103 form) was finalized (completed outside the EHR and scanned in if EHR a) within 60 OS/IOS, 28 days NTP (within physical), 10 days Residential, and WM areas deemed appropriate for urgent services from the date 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. If there are unknown areas, an explanation may be found in the service notes. For NTP/MAT providers this information is found within their own EHR within physical done by MD.					
G2	Update Health Questionnaire	If applicable, verify that per best practice, the Updated Health Questionnaire (5103 form) was completed (completed outside the EHR and scanned in if EHR) within the staff's clinical discretion (reasonable and in					



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		accordance with generally accepted standards of practice.) If there are unknown areas, an explanation may be found in the service notes. This item is optional and may be completed within the Assessment service Note. For NTP/MAT providers this information is found within their own EHR within physical done by MD.					
G3	Physical Health Conditions	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. (For NTP's within physical).					
G4	Linkage to PCP/GMC/ Alternative Healer	If client 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.					
G5	UA Documentation	Urinalysis results are documented (refer to service Notes). UA Log/results in file, plans or interventions to address results?					
G6	TB Test	TB skin test results documented (6 mo. prior to or 30 days after admit). Date Administered: _____ Date Read: _____ (If applicable for modality of service) (N/A for OS/IOS levels of care)					
G7	Chest X-Ray	Chest x-ray results documented. Date: _____ If applicable for modality of service (N/A for OS/IOS levels of care)					
G8	Annual TB Test	Annual TB skin test results / review of TB symptoms is documented. (N/A for OS/IOS levels of care) Date Administered: _____					



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		Date Read: _____					
G9	Physical Exam Requirements	Within 30 calendar days after enrollment, the physician reviewed the completed examination that was performed (within 12 months prior to enrollment date). MD to review and provide any appropriate linkage.					
COMMENTS							

H	MAT/NTP PHYSICAL EXAM REQUIREMENTS		Date completed:				
	Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response	
H1	Medical Intake	Medical Intake/Physical Exam Documented. Date: Click or tap to enter a date. _____					
H2	Vital Signs	Vitals Signs (temp, pulse, blood pressure, respiratory rate) were taken and documented.					
H3	Visual Exam	Visual Exam (head, ears, eyes, nose, throat, chest, abdomen, extremities, skin) was conducted and documented.					
H4	Evaluation of Organ System	An evaluation of the client's organ systems (pulmonary, liver, cardiac abnormalities, skin) was conducted and documented.					
H5	Evaluation of Neurological System	An evaluation of the client's neurological system was conducted and documented.					
H6	RPR Test	Test result for syphilis [typically antibody tests (serum): RPR reactivity] is documented.					
H7	TB Test	TB skin test results documented (6 mo. prior to or 30 days after admit). Date: _____					
H8	Annual TB Test	Annual TB skin test results / review of TB symptoms is documented. Date: _____					
H9	Chest X-Ray	Chest x-ray results documented. Date: _____					
H10	Overall Impressions	Overall impression of medical/health issues is documented.					



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H11	MD Statement of Dependence	Medical Director statement of evidence of physical dependence reviewed and documented before enrollment (e.g., symptoms, lab results).					
H12	Final Determination	Medical Director statement of final determination of physical dependence/addiction to opiates prior to enrollment.					
COMMENTS							

I	CARE PLAN	Requirements	Date Completed:				
			Completed	Reportable	N/A	Reviewer Comments	Program Response
I1	Initial Care Plan	Verify that per best practice, the Initial Care Plan was finalized within the service note within 60 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. Note: Care Coordination TCM/ICC services, Peer Support services require the Care Plan in a Service Note. NTP services are required in the Care Plan for all services Form within 28 days					
I2	Update/Care Plan	The Care plan within the Service Note should be updated when there are significant changes in the client's SUD condition or may be updated anytime when needed. The period to complete an updated Care Plan are up to clinical discretion (reasonable and in accordance with generally accepted standards of practice.) For NTP's (every 90 days) or within Title 9 treatment plan windows,					



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I3	Reasons for Service / Problem	The reasons for service/problem should reference those presenting problems identified in the assessment. The reasons should focus on the client’s SUD, including symptoms, behaviors, level of impairment, and psychosocial conditions such as living situation, daily activities, and social support.					
I4	Goals	SUD 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 member					
I5	Strengths & Barriers to Recovery	Plan should include strengths (positive assets) and barriers (difficulties or challenges).					
I6	Interventions: Detailed Description	Identifies a course of action to respond to the assessed needs of the member.					
I7	Interventions: Address assessed needs of the member	Includes activities such as ensuring the active participation of the member and working with the member (or the member authorized health care decision maker) and others to develop those goals.					
I8	EBP’s	The following Sacramento County approved Evidence-Based Practices (EBPs) were utilized: CBT <input type="checkbox"/> Psychoeducation <input type="checkbox"/> MI <input type="checkbox"/> Relapse Prevention <input type="checkbox"/>					



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		Trauma Informed <input type="checkbox"/>					
I9	Transition Plan	Include development of a transition plan when a member has achieved the goals of the care plan captured in a statement.					
I10	Staff's Signature on Care Plan	Verify that there is a qualified staff's electronic signature on the Care Plan and electronic co-signature if required.					
I11	Client Signature on Care Plan (SUBG) or other regulated funding requirement)	Verify that there is an electronic signature on the Care Plan.					
COMMENTS							

J PREGNANT AND PARENTING WOMEN							
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
J1	Engagement Activities	Engagement activities (Case Management/Referrals) were conducted. Date(s): _____ Activities: _____ appropriate documentation within the Interventions and identify needs and could mark accordingly above for quality of service when working with a pregnant client?					
J2	Treatment Services and Coordination	Treatment services were coordinated with other appropriate services, including health, criminal justice, social, educational, and vocational rehabilitation, well as additional services that are medically necessary to prevent risk to a fetus, infant, or mother. The provider arranged for transportation to ensure access to treatment. (Client/Care Plan)					



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J3	SUD Curriculum	SUD Curriculum included information to effectively minimize the risk of fetal exposure to drugs or alcohol, screening of pregnant women for continued substance use. (Specific to pregnant, peri-natal or gender specific programs)					
J4	Gender Specific Interventions	Gender-specific treatment and other therapeutic interventions for pregnant and parenting women, such as issues of relationships, sexual and physical abuse, and parenting were provided or arranged.					
J5	Services Addressed	Services addressed treatment issues specific to the pregnant and parenting women. Services included the following: (Service Notes)					
J6	Rehabilitative Services	Mother/child habilitative and rehabilitative services, such as parenting skills and training in child development;					
J7	Access	Access to services such as transportation;					
J8	Education	Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and					
J9	Coordination of Care Ancillary Services	Coordination of ancillary services, such as medical/dental, education, social services, and community services.					
J10	Care Coordination Provided	Care Coordination services were provided or arranged to ensure that pregnant and parenting women, and their children, have access to the following:					
J11	PCP	Primary medical care, including prenatal care;					
J12	Pediatric Care	Primary pediatric care, including immunizations;					
J13	Gender Specific	Gender specific treatment; and					
J14	Interventions for Children	Patenting includes therapeutic interventions for children to address developmental needs, sexual and psychological abuse, and neglect.					
J15	Children's Services and Referrals	Children's Services and referrals included: Clinical treatment services for the child that are deemed medically necessary, services should be comprehensive and, at a minimum,					



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		include the following: intake; screening and assessment of the full range of medical, developmental, emotional related-factors; care planning; residential care; case management; therapeutic child care; substance abuse education and prevention; medical care and services; developmental services; and mental health and trauma services as applicable to the program.					
COMMENTS							

K CLINICAL SERVICE NOTES							
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
K1	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.					
K2	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.					
K3	Services 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 response to care at the time the service was provided. .					
K4	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. Any EBP’s utilized.					
K5	Service Notes Content/Plan	Service notes must include: next steps including, but not limited to, planned action steps by the provider or by					



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		the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate.					
K6	Service Notes Out of Scope	Verify that the intervention provided was within the scope of practice of the practitioner.					
K7	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					
K8	Cultural Consideration	Client's cultural and language needs were explored, accommodated (e.g., the use of an interpreter) and documented					
K9	Outpatient Service Requirements	Up to 9 hours of Outpatient Services were provided per week (no requirements on the number of or duration of sessions)					
K10	Intensive Outpatient Service Requirements	A minimum of 9 hours with a maximum of 19 hours of Intensive Outpatient Services were provided per week (no requirements on the number of or duration of sessions).					
K11	MAT/NTP Service Note Requirements	Indicate program's response to any unfavorable UA result(s) [if applicable]					
K12	MAT/NTP Counseling Frequency Match	Counseling frequencies match (Client/Treatment Plan(s) and Service Notes)					
K13	MAT/NTP Requirement within Service Notes	Clients receiving 50 – 200 minutes of counseling [individual, including medical psychotherapy sessions, and group] each calendar month					



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K14	Residential Requirement within Service Note	Client received/participated in at least 20 hours of treatment per week, with one daily rate service provided at minimum. Justification documented within service notes if less than the requirement.					
K15	Withdrawal Management Requirement within Service Note	Daily service notes for monitoring, assessing for risk and stabilization					
K16	Group Services	When a group service is rendered, a list of participants is required to be documented and maintained by the provider. 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.					
K17	Non-Billable Services	Appropriate documentation of non-billable services, such as supervision, researching a topic, interpretation services, filing, faxing, educational services, transportation, etc.					
K18	Lockout Services	Appropriate documentation for services provided while the client was in a lockout situation, such as jail, juvenile hall, or psychiatric hospitalization					
K19	Service Notes that Need to be Amend 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 billing code of the service note and the reason for the disallowance. Please indicate if the service note needs to be amended or disallowed. The provider must submit the supplemental worksheet with the corrected McFloops if "Reportable" is selected. Selecting "Completed" means there are no progress notes that need to be amended or disallowed.					
K20	Service Note Timeliness	Verify that progress notes were completed within three business days of providing a service, with the exception of notes for crisis					



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		services, which shall be completed within 24 hours. NTP's are within 7 days.					
COMMENTS							

L GROUP COUNSELING/ATTENDANCE LOGS							
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
L1	Attendees List	Typed/legibly printed name of client attending the Group Counseling sessions.					
L2	Staff Attestation	Typed or legibly printed name, credentials, signature, and date from LPHA or AOD Counselor conducting the Group Counseling sessions.					
L3	Dates	Dates of Group Counseling sessions are documented.					
L4	Topic/Title of Group	Topic(s)/Title of Group Counseling Sessions are documented.					
L5	Start/End Times of Group	Start and end times of the Group Counseling sessions are documented.					
L6	Documentation within Service Note	Group Counseling Attendance logs match documentation in Service Notes and billing.					
L7	Group Size	Group Counseling Sessions included 2-12 participants (with the exception of psychoeducation groups clearly labeled).					
COMMENTS							

M MAT/NTP Dosing							
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
M1	Orders	An order exists to support the client's doses. Use Client Services Report to cross-reference.					
M2	Enrollment: Initial Dose	Enrollment: Initial dose did not exceed 30 mg, unless dose is divided, and subsequent dose is					



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		administered separately after prescribed observation period (exclude transitions).					
M3	First Day Dose	Total first day dose did not exceed 40 mg unless Medical Director documented that dosage was not sufficient to suppress the client's opiate abstinence symptoms (exclude transitions). Applies to Methadone only.					
M4	Step 1:	Step 1: A single take home if determined responsible for state approved holidays or Sunday closures.					
M5	Step 2:	Step 2: After 90 days of continuous maintenance treatment, up to 2 days take home supply, 5 observed doses per week.					
M6	Step 3:	Step 3: After 180 days of continuous maintenance treatment, up to 3 days take home supply allowed, 4 observed dose per week.					
M7	Step 4:	Step 4: After 270 days of continuous maintenance treatment, up to 6 days take home supply allowed: 1 observed doses per week.					
M8	Step 5:	Step 5: After 1 year of continuous maintenance treatment, up to 2 weeks take home supply allowed; 2 observed doses a month.					
M9	Step 6:	Step 6: After 2 years of continuous treatment, up to 1 month take home supply allowed, 1 observed dose per month.					
M10	Medical Director Review	Medical Director reviewed client's dosage level every 3 months (See Client/Treatment Plan or Medical Orders).					
M11	SAMHSA Take Homes	SAMHSA take home flexibilities following regulation included.					
M12	Courtesy Dosing: Length of Dosing	Member is providing dosing no more than 30 days (or have valid CSAT exception documented).					
M13	Courtesy Dosing: Required Documentation	Prior approval is obtained from the member's OTP/NTP Medical Director or program physician, allowing the member to receive services on temporary basis from another					



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		OTP/NTP. This can be found within the following document types/titles: Courtesy/Guest/Temporary Dosing form.					
M14	Courtesy Dosing: Consents	<p>The members signed and dated release of information and consent to the temporary OTP/NTP.</p> <p>A medication change order by the home OTP/NTP Medical Director or program that physician permits the member to receive services on a temporary basis from the other OTP/NTP for less than 30 days; and evidence that the Medical Director or program physician for the temporary OTP/NTP has accepted responsibility to treat the visiting beneficiary, concurs with his or her dosage schedule, and supervises the administration of the medication.</p> <p>This Consent, Responsibility can be found within the same form.</p> <p>Separate Medication Order form</p>					
M15	Buprenorphine Dosing	<p>Administered appropriately- split doses allowable within the same day.</p> <p>(Within the record there should be a separate informed consent for this type of medication).</p>					
M16	Buprenorphine Dosing Observation Requirement	<p>Observation between split doses (30 min observation) (Does not include injectables)</p>					
COMMENTS							



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N DISCHARGE PLANNING/SUMMARY		Date Completed:					
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
N1	Discharge/Transition Plan	Discharge/Transition Plan: Should be developed when a member has achieved the goals of treatment and documented with specific elements within a Service note.					
N2	Administrative Discharge	Administrative Discharge Summary should be used when discharge is unplanned and documented within a Service Note. This could also be utilized if an agency discharges for reasons involving breaking agency rules or due to member behaviors.					
N3	Copy of Discharge Plan if applicable (SUBG) or other regulated requirement)	A copy of the Discharge Plan was provided.					
COMMENTS							

O GENERAL DOCUMENTATION							
		Requirements	Completed	Reportable	N/A	Reviewer Comments	Program Response
O1	HIPAA	Guidelines were adhered to (no breaches of confidentiality, such as other person's info in member's chart, etc.)					
O2	Medical Necessity	Verify that the overall documentation in the chart justifies medical necessity.					
COMMENTS							



Substance Use Prevention and Treatment (SUPT) Electronic Utilization Review (EUR) Tool -Member Charts

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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 support was provided by SUPT 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?