**EUR SPECIFIED FIELDS**

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| Member Name:  | Member ID:  | U.R. Date:  |
| Provider and Program:  | Reviewer Name: |
| Review Period: | Intake First Medi-Cal Billable Service:  |
| Mid-Year [ ]  Annual [ ]  | Enrollment Date: Discharge Date (if applicable): |
| Funding: DMC-ODS[ ]  CalWORKs[ ]  Realignment[ ]  SUBG[ ]  SAMHSADT [ ]  | Level of Care:  |

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| **A** |

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| **CLIENT INFORMATION (CLIENT)/ SPECIAL POPULATION**  |

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|  |  | 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 |

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| 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.  |

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| **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. |  |  |  |  |  |
| 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 |  |

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| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
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| **D** | **SCAN DOCUMENT SECTION/COLLATERAL INFORMATION** |
|  |  | Requirements | Completed | Reportable | N/A | Reviewer Comments | Program Response |
| 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 | 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 member: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 member 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 thee) 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.  |  |  |  |  |  |
| 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. |  |  |  |  |  |
| 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. |  |  |  |  |  |
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| **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 5Updates | 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. |  |  |  |  |  |
| 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 whenservices 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. |  |  |  |  |  |
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| **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 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.

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| F2 | Update CA ASAMAssessment | 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 Cognitive Conditions and Complications  | Mental health history, behaviors and symptoms, previous services, risk factors and behaviors, types of abuse or trauma experienced. |  |  |  |  |  |
| 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, 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. |  |  |  |  |  |
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| **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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 |  |

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| **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. |  |  |  |  |  |
| 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 |  |

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| **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 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,  |  |  |  |  |  |
| 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 themember |  |  |  |  |  |
| 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 [ ]  Psychoeducation [ ]  MI [ ]  Relapse Prevention [ ] Trauma Informed [ ]   |  |  |  |  |  |
| 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. |  |  |  |  |  |
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| **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) |  |  |  |  |  |
| 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, 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 |  |

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

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| **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 |  |

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| **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 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 OTP/NTP. This can be found within the following document types/titles: Courtesy/Guest/Temporary Dosing form. |  |  |  |  |  |
| M14 | Courtesy Dosing: Consents | The members signed and dated release of information and consent to the temporary OTP/NTP.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.This Consent, Responsibility can be found within the same form.Separate Medication Order form |  |  |  |  |  |
| M15 | Buprenorphine Dosing | Administered appropriately- split doses allowable within the same day. (Within the record there should be a separate informed consent for this type of medication). |  |  |  |  |  |
| M16 | Buprenorphine Dosing Observation Requirement | Observation between split doses (30 min observation)(Does not include injectables) |  |  |  |  |  |
| 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 |  |

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| **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 |  |

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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?
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