Sacramento County Electronic Utilization Review Tool

MENTAL HEALTH URGENT CARE CLINIC ELECTRONIC UTILIZATION REVIEW TOOL

Member Name:	Member ID:	U.R. Date:
Provider and Program: Mental Health Urgent Care Clinic		Reviewer Name:
Review Period:		Enrollment Date:

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							

Revised: 10/1/2023

Sacramento County Electronic Utilization Review Tool

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							

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Sacramento County Electronic Utilization Review Tool

D	DIAGNOSIS/PROBLEM LIST					Diagnosis Date:	
		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	Self-Report Crisis Triage Outcome	Verify that the Self-Report Crisis Triage Outcome Form was completed and includes Vitals, Member Health History and Disposition, and that it was scanned into the client's record.					
E7	Mental Health Urgent Care Triage Outcome Form: LPHA Review	Verify that the Mental Health Urgent Care Triage Outcome Form (result of Self-Report Triage Check List) is reviewed as evidenced by an LPHA signature.					
E8	Vitals	Verify that vitals have been entered into the "Enter vitals" screen in SmartCare.					
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Sacramento County Electronic Utilization Review Tool

F	CRISIS ASSESSMENT (CLIENT)					Date completed:	
		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:**	
		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.					
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Sacramento County Electronic Utilization Review Tool

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							

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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?	

Revised: 10/1/2023