Medical Record Review Survey
Substance use Disorder (SUD) Treatment Services

No. of LPHA/MD_____

Facility Name:_____ **Site ID:**_____ **Review Date** _____ **No. of Records**_____

Provider _____ **Phone** _____ **Fax** _____

Address_____ **Contact person/title** _____

City/Zip Code_____ **Reviewer/title** _____ **Reviewer/title** _____

Visit Purpose	Site-Specific Certification(s)	Clinic type
_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____ (type)	DMC Certification_____ ASAM Designation_____ **(For Residential Programs)**	___ Outpatient (1) ___ Perinatal Outpatient (1) ___ Intensive Outpatient (2.1) ___ Intensive Perinatal Outpatient (2.1) ___ Residential (3.1) ___ Withdrawal Management. (3.2) ___ Residential 3.5)* ___ Perinatal Residential (3.5) ___ OTP ___ Other

Scoring Procedure

		Points possible	Yes Pts. Given	No's	N/A's	Section Score %
I.	**Format**	**(9) X 10 = 90**				
II.	**Intake Services**	**(16) x 10 = 160**				
III.	**Treatment Services**	**(32) x 10 = 320**				
IV.	**Discharge Services**	**(13) x 10 = 130**				
V.	**Recovery Services**	**(4) x 10 = 40**				
VI.	**Residential**	**(3) x 10= 30**				
		Total Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Medical Record Scores

Scoring is based on **10** medical records.

1) Add points given in each section.
2) Add points given for all six (6) sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

_____ (Points Given) ÷ _____ (Total/ Adjusted Pts. Poss.) = _____ (Decimal Score) **x 100** = _____% (Compliance Rate)

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

_____**Exempted Pass: 90% or above:** (Total score is ≥ 90% *and* all section scores are 80% or above)

_____**Conditional Pass: 80-89%:** (Total MRR is 80-89% *OR* *any* section(s) score is < 80%)

_____**Not Pass: Below 80%**

_____CAP Required

_____Other follow-up

Next Review Due: _____

Medical Record Review for Substance Use Disorder (SUD) Treatment Services

California Department of Health Care Services
Medi-Cal Managed Care Division

Purpose: Medical Record Review Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey, and shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Survey score is based on a review standard of 10 records per Licensed Practitioner of the Healing Arts (LPHA). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each LPHA. Sites where documentation of patient care by all LPHA on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each LPHA sharing the records. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "**RN/MD/LPHA Review only".**

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single LPHA. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all six (6) sections. (Format points given) (Intake Services points given) (Treatment Services points given) + (Discharge Services points given) (Recovery Services points given) (Residential points given) **= (Total points given)**
Step 3: Subtract the "N/A" points from total points possible. (Total points possible) – (N/A points) = ("Adjusted" total points possible)	**Step 4**: Divide total points given by the "adjusted" points possible, then multiply by 100 to calculate percentage rate. Total points given / "Adjusted" total points possible Example: 267 / 305 = 0.875 X 100 = **88%**

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Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	**AOD 12020**, "A separate, complete, and current record shall be maintained at the program for each client. Programs shall develop any necessary forms. All client files shall contain demographic information sufficient to identify the client and to satisfy data collection needs of the program and funding agencies."
B. Chart contents are securely fastened and consistently organized.	Printed chart contents are securely fastened, attached or bound to prevent record loss. Electronic record information is readily available. Charts are consistently organized. This is per PHC requirements.
C. Medical records are retained for a minimum of 10 years.	Chart records must be confidentially secured and kept for no less than 10 years. Per the **Intergovernmental Agreement, under 42 CFR 438,** DHCS and CMS may audit for ten (10) years. Subcontractors are required to agree to grant state and federal oversight agencies the right to inspect books, contracts, computer or other systems that pertain to the services performed and to make materials available for audit for ten years from the completion of any audit, whichever is later.
D. Relevant services offered to perinatal patients.	Per **Title 22 (page 11-12 Documentation, Modalities and Services)** these services must be offered to perinatal patients under **DMC-ODS** services. Relevant services include: 1) Mother/child rehabilitative services. 2) Education provided on the harmful effects of drugs and alcohol on the mother and fetus or infant. 3) Evidence of coordination of ancillary services in the case management note. 4) Proof of pregnancy and/or delivery.
E. ASAM Assessment for Adolescent Services	Clients age 12-21 years have received ASAM assessment and meet the adolescent treatment criteria for care that is being provided. ASAM – The 5 Levels of Addiction Treatment According to the widely used ASAM adolescent placement criteria, there are 5 basic levels of teen addiction treatment. **The 5 levels of care are:** Level 0.5 – Early intervention Level 1 – Outpatient Level 2 – Intensive outpatient treatment or partial hospitalization Level 3 – Residential or intensive inpatient treatment Level 4 – Medically managed intensive inpatient treatment To determine an appropriate level of care, professionals look at the situation across 6 assessment dimensions, which are: **Acute intoxication and withdrawal** – looking at how much medical management of withdrawal might be needed, for example. **Biomedical complications** – assessing for other health conditions that might complicate the recovery process. **Emotional, behavioral and cognitive conditions or complications** – looking for other mental health, developmental or behavioral conditions that might complicate the recovery process and lead to a higher level of care requirement. **Readiness to change** – the more ready and motivated for change the lower the treatment intensity that is required. **Relapse or continued use potential** – teens able to control use and maintain abstinence for moderate periods require less intensive treatment than teens unable to stop for even short periods of time. **Recovery environment** – Teens without a safe and stable recovery environment may require higher intensity care, such as residential treatment, to make lasting gains. **The ASAM shall be completed within 14 days of the first face-to-face interaction for youth.**
F. Timeliness of initial face-to-face visit.	The first face-to-face appointment shall occur within 15 calendrer days of initial contact at all Levels of Care.

I. Format Criteria

Note: A Format section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. An individual medical record is established for each member.	**1**											
B. Chart contents are securely fastened and consistently organized.	**1**											
C. Medical records are retained for a minimum of 10 years	**1**											
D. Relevant services offered to perinatal patients.												
1) Access to mother/child rehabilitative services.	**1**											
2) Education provided on the harmful effects of drugs and alcohol on the mother and fetus or infant.	**1**											
3) Evidence of coordination of ancillary services in the case management note.	**1**											
4) Proof of pregnancy and/or delivery.	**1**											
E. ASAM Assessment for Adolescent Services	**1**											
F. Timeliness of initial face-to-face visit.	**1**											
	Yes											
	No											
	N/A											

Comments:

9 Pts. Possible

Criteria	II. Intake Services Reviewer Guidelines
A. Appropriate documentation of admission and readmission criteria.	Each provider shall include in its policies, procedures and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at minimum: • DSM diagnosis • Use of alcohol/drugs abuse • Physical health status • Documentation of social and psychological problems
B. Medical Necessity determined appropriately.	Medical necessity must be performed in a face-to-face or telehealth (video-conference) review by either a medical director or a LPHA. **Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i.** *This is part of a DHCS decision to make this a mandatory step in Medical Necessity Determination for waiver beneficiaries (see waiver). The intake information is compared to the DSM-IV criteria. A diagnosis is made if enough criteria are met to support the diagnosis. The ASAM criteria is compared to the DSM diagnosing criteria, and the level of care is then determined. **The diagnosis and medical necessity determination shall be completed within 15 calendar days of the first face-to-face interaction.**
C. Medical record contains signed Client Rights document.	There is evidence of a Client's Rights document available in the client file for review.
D. Medical record contains signed Consent to Treatment document.	The beneficiary shall sign a consent for treatment form.
E. Medical record contains signed Program Rules document.	There is evidence of a Program Rules document signed and in the client file for review.
F. Medical record contains signed admission agreement.	There is evidence of an Admission Agreement and in the client file for review.
G. Medical record contains evidence of Medi-Cal/PHC eligibility verification.	There is evidence of PHC or Medi-Cal eligibility in the client file for review.
H. Medical record contains signed Follow-Up Consent document.	There is evidence of a Follow-Up Consent signed and in the client file for review.
I. Medical record contains documented physical exam.	A physical exam must be in the patient's chart. The SUDS Clinician Must either: a. Obtain a copy of the most recent physical exam (if one was completed in the last 12 months). The exam can only be reviewed by a Physician. **OR** b. Perform a new exam. The exam must be performed by a Physician, PA, or Nurse Practitioner (N.P.). c. Put in Treatment Plan goals. d. Contact Care Coordination (CC) in Partnership Health Plan to help set up unestablished member with a network PCP provider to perform a physical exam. 22 CCR § 51303, 42 CFR § 438.210(a)(4) **NOTE: This must be done within *30 days* of admission into program.** **PHC contract states if client has not been seen in longer than 6 months, client will be referred to PHC Care Coordination department aid in receiving medical care.**

II. Intake Services

Note: An Intake Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Appropriate documentation of admission and readmission criteria.	**1**											
B. Medical Necessity is determined appropriately.	**1**											
C. Medical record contains signed Client Rights document.	**1**											
D. Medical record contains signed Consent to Treatment document.	**1**											
E. Medical record contains signed Program Rules document.	**1**											
F. Medical record contains signed admission agreement.	**1**											
G. Medical record contains evidence of Medi-Cal/PHC eligibility verification.	**1**											
H. Medical record contains signed Follow-Up Consent document.	**1**											
I. Medical record contains documented physical exam.	**1**											

Criteria	II. Intake Services Reviewer Guidelines (Continued)
J. Medical record contains a signed Consent to Release Information document.	There is evidence of a Consent to Release Information document signed and in the client file for review. This is per **42 CFR.**
K. Medical record contains signed HIPAA notification.	There is evidence of a HIPAA (Health Information Portability and Accountability Act) signed and in the client file for review.
L. Missed appointments and outreach efforts are consistently documented in the client's chart.	There must be documentation of at least 3 outreach efforts from the facility to the client for engagement in treatment.
M. Medical record contains evidence the provider accepts proof of eligibility as payment.	**Per Title 22,** providers must accept proof of Medi-Cal/PHC eligibility as payment in full for treatment services rendered upon intake and monthly. **NOTE**: This is ***except*** when there is a share of cost (SOC).
N. Medical record contains evidence of ASAM criteria used to determine medical necessity.	Adult clients must meet the ASAM criteria definition of medical necessity for services based on the ASAM criteria. American Society of Addiction Medicine (ASAM) Criteria shall be applied by the diagnosing individual (Medical Director or LPHA) to determine placement into the level of assessed services. **Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i.** • **ASAM level of Care data shall be entered into the designated system for each assessment or re-assessment and within 7 days of the assessment/re-assessment. The ASAM assessment shall be completed within 7 days of the first face-to-face interaction for adults.** **THE MEDICAL DIRECTOR OR LPHA SHALL REVIEW EACH BENEFICIARY'S PERSONAL, MEDICAL AND SUBSTANCE USE HISTORY IF COMPLETED BY A COUNCELOR.**
O. Medical record contains evidence of appropriate documentation during intake.	The provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment. The history shall be completed during the first face-to-face interaction. Assessment for all beneficiaries shall include at a minimum: Drug/alcohol use history; Medical history; Family history; Psychiatric/psychological history; Social/recreational history; Financial status/history; Educational history; Employment history; Criminal history, legal status, and previous SUD treatment history.
P. There is evidence of at least two Evidence Based Practices (EBPs) being used.	Providers will implement at least two of the following Evidence Based Practices (EBPs) in patient's treatment. They are as follows: • **Motivational Interviewing**: this approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. • **Cognitive- Behavioral Therapy**: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned. • **Seeking Safety:** teaches present-focused coping skills to help clients attain safety in their lives. • **Trauma-Informed Treatment**: Services must take into account an understanding of trauma, and place priority on trauma survivor's safety, choice and control. • **Living in Balance:** helps address issues in lifestyle areas that may have been neglected during addiction.

II. Intake Services (Continued)

Note: An Intake Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
J. Medical record contains a signed Consent to Release Information document.	**1**											
K. Medical record contains signed HIPAA notification.	**1**											
L. Missed appointments and outreach efforts are consistently documented in the client's chart.	**1**											
M. Medical record contains evidence the provider accepts proof of eligibility as payment.	**1**											
N. Medical record contains evidence of ASAM criteria used to determine medical necessity.	**1**											
O. Medical record contains evidence of appropriate documentation during intake.	**1**											
P. There is evidence of at least two Evidence Based Practices (EBPs) being used.	**1**											
Comments:	Yes											
	No											
	N/A											

16 Pts. Possible

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	III. Treatment Services Reviewer Guidelines
A. Medical record contains the most recent Treatment Plan.	The most recent treatment plan must be in the file.
B. Medical record contains treatment plan legibly signed during appropriate timeframe.	**Signature:** If the MD or LPHA deem the services in the initial treatment plan medically necessary, they must print their name, sign, and date the treatment plan within ***15 calendar days*** of being signed by the counselor. Withdrawal Management within one business day of admission. • It must be signed by the beneficiary (client) and the counselor within ***30 days*** of admission to treatment. • IF the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment. **Note: If ALL signatures are not within the total 30 day timeframe, Services rendered in that time will be ineligible for payment.** **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.
C. Treatment Plan is consistent with issues per the client.	Per **Title 22**, the statement of problems should match the assessment. Goals to be reached need to address each problem the patient presents with. Action steps refer to activities and interventions which will be taken to accomplish the goal(s). Target dates are dates set in place for when the action steps are scheduled to be accomplished. • Statement of problems • Goals including goal of obtaining a physical exam if needed, and goal of obtaining treatment for an identified significant medical illness if needed • Action steps • Target dates • Type and frequency of counseling/services • Diagnosis as documented by the Medical Director or LPHA • Assignment of primary therapist or counselor • If the beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination is required • If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness. • **Timeframe:** Within 30 calendar days from beneficiary's admission to treatment **NOTE: ALL elements need to be present in order to receive points for this criteria.**
D. Medical record contains evidence of client participation in the development of the treatment plan.	There is evidence in the Treatment plan documentation that the client played an active role in creating the plan.

III. Treatment Services

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Medical record contains the most recent Treatment Plan.	**1**											
B. Medical record contains treatment plan legibly signed during appropriate timeframe.	**1**											
C. Treatment Plan is consistent with issues per the client.	**1**											
D. Medical record contains evidence of client participation in the development of the treatment plan.	**1**											

Comments:

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	III. Treatment Services Reviewer Guidelines (Continued)
E. Attendance at counseling sessions are appropriately documented in the chart.	According to **AOD 8000 c. 1-4,** "The following documentation of attendance at each individual counseling session and group counseling session shall be placed in the client's file: 1. Date of each session attended; 2. Type of session (i.e., individual or group); 3. Signature of counselor who conducted the session; and 4. Notes describing progress toward achieving the client's treatment plan or recovery plan goals". This is also illustrated in **§ 51341.1. Drug Medi-Cal Substance Use Disorder Services.**22 CA ADC § 51341.1
F. Progress notes contain the minimum required documentation according to Tittle 22 and AOD 7100b.	For Outpatient, Intensive Outpatient, Naltrexone Treatment, and Recovery Services, the Progress Note consists of all of the minimum components spelled out in the AOD 7100 b. Per **Title 22 and AOD 7100 b**, LPHA or Counselor must have these elements in their progress notes for **all** patients enrolled in outpatient services: 1) Topic of the session 2) Description of beneficiary's progress toward treatment plan goals 3) Date of each treatment service 4) Start and end time of each treatment service 5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) **within 7 days of the session** 6) Identify if service was in-person, telephone or telehealth 7) Document location of service and how confidentiality was maintained if provided in the community 8) If case management services are provided, additional criteria of: a description of how the services relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referral. **NOTE: ALL elements need to be present in order to receive points for this criteria.**
G. Medical record contains evidence of the required number of monthly counseling sessions.	Per **Title 22 and AOD standards,** there must be a minimum of two individual or group counseling sessions provided to the client every month in the Outpatient setting.
H. Progress notes contain a narrative of treatment plan progress, goals, and action steps.	Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps. The progress note must contain this documentation in order to receive points on this criteria. This is crucial to insuring that the care and action steps taken are individualized to the client identified needs and consistent with the treatment plan goals.
I. Medical record contains the minimum number of progress notes.	In Residential Care and Intensive Outpatient Care, there is a minimum of one progress note per calendar week. If applicable, the progress notes must contain dates and duration of group counseling sessions and have to be signed within the week following the calendar week when the counseling sessions were provided.

III. Treatment Services (Continued)

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
E. Attendance at counseling sessions are appropriately documented in the chart.	**1**											
F. Progress notes contain the minimum required documentation according to Tittle 22 and AOD 7100b.												
1) Topic of the session	**1**											
2) Description of beneficiary's progress toward treatment plan goals.	**1**											
3) Date of each treatment service.	**1**											
4) Start and end time of each treatment service.	**1**											
5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) **within 7 days of the session**	**1**											
6) Identify if service was in-person, telephone or telehealth	**1**											
7) Document location of service and how confidentiality was maintained if provided in the community	**1**											
8) **If <u>case management services</u> are provided:** additional criteria of: a description of how the services relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referral.	**1**											
G. Medical record contains evidence of the required number of monthly counseling sessions.	**1**											
H. Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps.	**1**											
I. Medical record contains the minimum number of progress notes.	**1**											

Comments:

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	III. Treatment Services Reviewer Guidelines (Continued)
J. Program provides individual and group counseling sessions to clients.	According to **AOD 8000 a**., "The program shall provide individual and group counseling sessions for clients. Family members and other persons who are significant in the client's treatment and recovery may also be included in sessions. Individual and group counseling sessions shall be directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources. Emphasis shall be placed on the recovery continuum appropriate to clients' needs."
K. Group sign in sheets include the printed names, signatures, dates, start and end times and topic of discussion.	Sign in sheets **MUST** include all of these components: 1) Printed name and signature of the client 2) Printed name, title and signature of the counselor 3) Date of session 4) Start and end times 5) Topic 6) List of the participants' names (printed or legibly written) and the signature of each participant that attended the counseling session.
L. Counseling Groups consist of between 2 and 12 clients.	The Counseling Group must consist of between 2 and 12 clients per **Title 22**: "(B) For day care habilitative services, group counseling shall be conducted with no less than two and no more than twelve clients at the same time, only one of whom needs to be a Medi-Cal beneficiary."
M. Medical record contains evidence of provision or offer of services outlined under Title 22.	There are services provided, and documented directly by the treatment facility, or there are referrals made for the following services: educational, vocational, counseling, job referral, legal services, medical and dental services, social and recreational services. Under **Title 22**, services must be provided or offered to the client receiving Substance Use Disorder Treatment Services for- education, vocation, counseling, job referral, legal, medical, and dental, social and recreational. Case management
N. Medical record contains evidence of collaboration on treatment goals and recovery plan.	According to **AOD 7110, "**Before active program participation is concluded and prior to program approved discharge, a counselor shall meet with each client to develop a continuing recovery plan that includes individual strategies to assist the client in sustaining long-term recovery. The continuing recovery or discharge planning process shall be inclusive of the goals identified in the treatment plan and the previous recovery plan and shall include referrals to appropriate resources."
O. Medical record contains evidence of provider coordination of care and provider	Both the discharging and admitting PROVIDER agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in the beneficiary record. **Performance Standard: Transitions between levels of care shall occur within five (5) and no longer than ten (10) business days from the time of re-assessment indicating the need for a different level of care.** The PROVIDOR shall screen for and link clients with mental and physical health, as indicated. Also ensure that beneficiaries have access to recovery supports immediately after discharge or upon completion of an acute stay. A **warm hand** off is an interaction that happens in person between members of the transferring and receiving provider in front of the client and family (if present).

III. Treatment Services (Continued)

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
J. The program provides individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.	**1**											
K. Group sign in sheets include required elements below:												
1) Printed name and signature of the client	**1**											
2) Printed name, title and signature of the counselor	**1**											
3) Date of session	**1**											
4) Start and end times	**1**											
5) Topic	**1**											
6) List of the participants' names (printed or legibly written) and the signature of each participant that attended the counseling session.	**1**											
L. Counseling Groups consist of between 2 and 12 clients.	**1**											
M. Medical record contains evidence of provision or offer of services outlined under Title 22.	**1**											
N. Medical record contains evidence of collaboration on treatment goals and recovery plan.	**1**											
O. Medical record contains evidence of provider coordination of care and provider	**1**											

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	III. Treatment Services Reviewer Guidelines (Continued)
P. Medical record contains evidence of justification for continuation of treatment services exceeding 6 months.	Identifying the DSM diagnostic code and establishing the medical necessity for treatment and services, and justifying the need to continue services must include documentation of the following: 1) Beneficiary's personal, medical and substance abuse history; 2) Documentation of most recent physical examination; 3) Progress notes and treatment plan goals; 4) LPHA's or counselor's recommendations; 5) Beneficiary's prognosis. The continuing services justification must be completed ***no sooner than 5 months*** and ***no later than 6 months*** after the admission date. The physician must determine continuing medical necessity and justification must include prognosis and the counselor's recommendation for continuing treatment.
Q. Medical record contains evidence that ongoing treatment plan meets Title 22 requirements.	The Ongoing Treatment Plan must be: • Completed at MOST 90 days after the signing of the initial Treatment Plan. • Signed by the counselor within 90 days after the initial Treatment plan. • Signed by the client within 30 days of being signed by the counselor. The ongoing Treatment plan must have a signature from the LPHA/MD within 15 days of being signed by the client. Per **Title 22,** It is mandatory for the ongoing treatment plan to be completed no later than 90 days after the initial treatment plan and must be signed by the counselor within 90 days after the initial treatment plan, signed by the client within 30 days of the counselor's or LPHA's signature, and signed by the MD/LPHA within 15 days of being signed by the client. • **If beneficiary refuses to sign updated treatment plan, then document reason for refusal and document strategies to engage beneficiary to participate in treatment.** **Note: All Signatures must be present and within the appropriate timeframe in order to get the point for this criteria.**
R. Medical record contains documentation of TB test and results.	A positive test and/or chest x-ray confirming Tuberculosis will be used to confirm the level of care that must be provided to the client. There has been Tuberculosis (TB) testing done and care received based on results.
S. Medical record contains evidence that TB services are provided or offered to clients receiving SUD treatment.	It is mandatory for Tuberculosis services to be offered with a diagnosis of Tuberculosis (TB). The program ensures that Tuberculosis (TB) services are available and offered to clients receiving Substance Use Disorder (SUD) Treatment including counseling, testing, and referral. If denied admission to the program due to lack of capacity, there is evidence of referral to other providers.

III. Treatment Services (Continued)

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
P. Medical record contains evidence of justification for continuation of treatment services exceeding 6 months.	**1**											
Q. Medical record contains evidence that ongoing treatment plan meets Title 22 requirements.	**1**											
R. Medical record contains documentation of TB test and results.	**1**											
S. Medical record contains evidence that TB services are provided or offered to clients receiving SUD treatment.	**1**											
	Yes											
	No											
	N/A											

Comments:

32 Points Possible

Rationale: Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment.

Criteria	IV. Discharge Services Reviewer Criteria
A. Discharge plan present for each client.	Per **Title 22:** "A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact." If the medical director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to go to an appropriate level of treatment services. Discharge plan should include the following: • A description of each of the beneficiary's relapse triggers. • A plan to assist the beneficiary to avoid relapse when confronted with a trigger • A support plan The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary. The discharge plan shall be completed by the time of transfer if moving to a different level of care.
B. The discharge plan is signed by both the client and the counselor	During the LPHA's or counselor's last face-to-face treatment with the beneficiary , the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record. **This is N/A if the provider loses contact with the client.**
C. If client was unavailable to complete a Discharge Plan, the *Discharge Summary* was completed within 30 days of the last face-to-face contact with the client.	This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client.
D. Discharge summary for clients who terminate services include required elements according to AOD7120b.	According to **AOD 7120 b. ,** A discharge summary that includes: 1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program; 2) Description of treatment episodes; 3) Description of recovery services completed 4) Current alcohol and/or other drug usage 5) Vocational and educational achievement 6) Client's continuing recovery or discharge plan signed by counselor and client 7) Transfers and referrals 8) Client's comments 9) Beneficiary's prognosis 10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode. **Note: Must meet all of this criteria in order to receive the point.**

IV. Discharge Services

Note: A Discharge Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Discharge plan present for each client.	**1**											
B. The discharge plan is signed by both the client and the counselor.	**1**											
C. If client was unavailable to complete a Discharge Plan, the Discharge Summary was completed within 30 days of the last face-to-face contact with the client.	**1**											
D. Discharge summary for clients that terminate services include required elements according to AOD7120b.												
1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;	**1**											
2) Description of treatment episodes;	**1**											
3) Description of recovery services completed	**1**											
4) Current alcohol and/or other drug usage	**1**											
5) Vocational and educational achievement	**1**											
6) Client's continuing recovery or discharge plan signed by counselor and client	**1**											
7) Transfers and referrals	**1**											
8) Client's comments	**1**											
9) Beneficiary's prognosis	**1**											
10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.	**1**											
Comments:	Yes											
	No											
	N/A											

13 Points Possible

Rationale: Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.

Criteria	V. Recovery Services Reviewer Criteria
A. Recovery Services provided are based on beneficiary directed concerns established in the Recovery Plan.	Beneficiary concerns are identified (triggers, relapse, preventative measures to prevent relapse). There needs to be clear evidence that there is a focus on coordination of care for the identified individual needs of the beneficiary.
B. Recovery Discharge is appropriately documented.	Recovery Discharge summary must be completed within 30 days of the last face-to-face client contact.
C. The Recovery Plan includes information on relapse triggers, proposed coping strategies, and a support plan.	**Per AOD 7100 a**, Support plan, proposed coping strategies and information on relapse triggers need to be included in the Recovery Plan. "a. If a program develops a recovery plan, it shall include the following: 1. A statement of challenges the client expects to encounter during recovery. 2. A statement detailing methods of handling the challenges of recovery. 3. A statement of actions that will be taken by the program and/or client to prepare for the challenges of recovery."
D. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 30 days.	Adult beneficiaries in Residential treatment shall be re-assessed at a minimum every 30 days (since they will be assessed on day one). Youth beneficiaries in residential treatment shall be re-assessed at a minimum of every 30 days, unless there are significant changes warranting more frequent reassessments.

V. Recovery Services

Note: A Recovery Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Recovery Services provided are based on beneficiary directed concerns established in the Recovery Plan.	**1**											
B. Recovery Discharge is appropriately documented.	**1**											
C. The Recovery Plan includes information on relapse triggers, proposed coping strategies, and a support plan.	**1**											
D. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 30 days	**1**											
	Yes											
	No											
	N/A											

Comments:

4 Points Possible

Rationale: These guidelines are pulled from the DHCS website http://www.dhcs.ca.gov/provgovpart/Pages/Incidental-Medical- Services.aspx.

Criteria	VI. Residential Reviewer Criteria
A. Medical record contains evidence of prior authorization for services.	Residential Treatment requires a Prior Authorization for services.
B. There is oversight of self-administered medications.	There is documentation present in the chart that illustrates oversight of patient's taking their medication.
C. The Residential Program provides the opportunity for the client to participate in planned recreational activities.	Per **AOD 10000,** "Residential programs shall provide the opportunity for clients to participate in planned recreational activities."

VI. Residential

Note: A Residential Treatment section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Medical record contains evidence of prior authorization for services.	**1**											
B. There is oversight of self- administered medications.	**1**											
C. The Residential Program provides the opportunity for the client to participate in planned recreational activities.	**1**											
Comments:	**Yes**											
	No											
	N/A											

3 points possible

Reviewer Comments:

If more than one Reviewer, both must sign here.

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____