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

No. of Records: _____

Facility Name		**Site ID**		**Date of Review**	
Full Address		**Phone**		**Fax**	
Contact Name/Title			**Email**		
Reviewer Name/Title					

Visit Purpose		**Clinic Type/Level of Care**
☐ **Initial Full Scope** ☐**Monitoring** ☐ **Periodic Full Scope** ☐**Follow-up** ☐ **Focused Review** ☐**Ed/TA** ☐ **Other** _____ **(type)**		☐ Outpatient (1) ☐ Perinatal Outpatient (1) ☐ Intensive Outpatient (2.1) ☐ Intensive Perinatal Outpatient (2.1) ☐ Youth/Adolescent If Youth services are offered in conjunction with regular services, at least 50% of charts must be that modality Residential ☐3.1 ☐3.3 ☐3.5 ☐3.7 ☐4.0 Perinatal Residential ☐3.1 ☐3.3 ☐3.5 ☐3.7 ☐4.0 ☐ Withdrawal Management. (3.2) ☐ OTP/NTP If Perinatal services are offered in conjunction with regular services, at least 50% of charts must be that modality

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.

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

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

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 nine (9) sections. (Format points given) (Intake Services points given) (Care Planning Guidelines – treatment plans – NTP Only points given) (Care Planning Guidelines – Problem Lists – All LOC *except NTP* points given) (Treatment Services points given) (Discharge Services points given) (Care Coordination Services points given) (Residential Services points given) (Perinatal/Family Services 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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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.

I. Format Criteria

Criteria Met=Yes **Criteria not Met=No** **Not applicable= N/A**		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Age/Gender												
Admission Date												
Discharge Date												
A. An individual medical record is established for each member.	**1**											
B. Chart contents are securely fastened and consistently organized.	**1**											

Comments:

Criteria	II. Intake Services Reviewer Guidelines
A. 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.** A signed release of information (ROI) is present and includes Partnership HealthPlan, the County, and entities that assist in the coordination of care indicated in the treatment plan.
B. Medical record contains signed HIPAA notification.	There is evidence of a HIPAA (Health Information Portability and Accountability Act) notification signed and in the client file for review.
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/Partnership eligibility verification.	There is evidence of Partnership or Medi-Cal eligibility in the client file for review.
H. Medical record contains a documented physical exam.	A physical exam must be in documented in the patient's chart within 30 days of admission into program. 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, PA, or Nurse Practitioner (N.P.). b. **OR** c. Perform a new exam. The exam must be performed by a Physician, PA, or Nurse Practitioner (N.P.). d. Contact Partnerships Care Coordination (CC) team to assist the member with establishing a PCP provider that will be able to perform the necessary physical exam. • Perinatal Patients o Physician shall review the most recent physical examination within 30 days of admission to treatment. The physical examination should be within a 12 month period prior to the admission date. • Alternatively, a physician or non-physician medical practitioner may perform a physical examination within 30 calendar days of admission. 22 CCR § 51303, 42 CFR § 438.210(a)(4) **PHC contract states if client has not been seen in longer than 6 months, client will be referred to Partnerhsip Care Coordination department to aid in receiving medical care.**

I. Medical Record indicates MAT services were offered or member was referred	
J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.	

II. Intake Services

Criteria Met=Yes **Criteria not Met=No** **Not applicable= N/A** **Criteria met: Give one (1) point.** **Criteria not met: 0 points** **Criteria not applicable: N/A**		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 a signed Consent to Release Information document.	**1**											
B. Medical record contains signed HIPAA notification.	**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/Partnership eligibility verification.	**1**											
H. Medical record contains a documented physical exam within 30 days of admission.	**1**											
I. Medical Record indicates MAT services were offered or member was referred	**1**											
J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.	**1**											

Comments:

Criteria	II. Intake Services Reviewer Guidelines (Continued)
K. 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
L. 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. For beneficiaries 21 and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain. For beneficiaries under 21 years of age, a service is deemed medically necessary if the service can improve or correct a screened health condition, such as SUD. The service does not have to correct the issue. It can sustain, support, improve or make the condition more tolerable to be necessary. These services are covered under Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. **The diagnosis and medical necessity determination shall be completed within 30 calendar days of the first face-to-face interaction. Medical necessity determination for homeless patients shall be completed within 60 days.**
M. Missed appointments and outreach efforts are consistently documented in the client's chart.	There must be documentation from the facility to the client for engagement in treatment. Medical record contains documentation of missed/excused group sessions and/or individual counseling sessions.
N. Medical record contains evidence the provider accepts proof of eligibility as payment.	**Per Title 22,** providers must accept proof of Medi-Cal/Partnership 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).
O. Medical record contains evidence of ASAM criteria used to determine medical necessity.	• • American Society of Addiction Medicine (ASAM) Criteria shall be documented by the diagnosing individual (Medical Director or LPHA) and used to determine placement and level of services needed. Adults must meet the ASAM criteria definition of medical necessity for services. • Providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. • The assessment shall include a typed or legibly printed name of the service provider, provider signature , provider title (or credentials), and date of signature- • Assessments shall be updated as clinically appropriate, or as needed if the member's condition changes • For adolescent clients, a developmentally appropriate ASAM tool shall be used • RESIDENTIAL ASAM Criteria Assessment is required before a DMC-ODS plan authorizes a residential treatment level of care. **AUTOMATIC CAP IF ASAM IS NOT COMPLETED
P. 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.

II. Intake Services (Continued)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
K. Appropriate documentation of admission and readmission criteria.	**1**											
L. Medical Necessity is determined appropriately.	**1**											
M. Missed appointments and outreach efforts are consistently documented in the client's chart.	**1**											
N. Medical record contains evidence the provider accepts proof of eligibility as payment.	**1**											
O. Medical record contains evidence of ASAM criteria used to determine medical necessity.	**1**											
P. Medical record contains evidence of appropriate documentation during intake.	**1**											

Comments:

Criteria	III. Care Planning Guidelines – Treatment Plans – NTP ONLY
A. Medical record contains the most recent Treatment Plan.	The most recent treatment plan must be in the file.
B. Medical record contains a legibly signed treatment plan 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 client specific and AOD 7110 compliant.	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 should include: Target dates
	  • Type and frequency of counseling/services
	  • Diagnosis as documented by the Medical Director or LPHA
	  • Assignment of primary therapist or counselor
	  • Documentation of physical exam requirements
	  • Documentation demonstrates the client played an active role in creating the treatment plan.
	  • Recovery/discharge plan is part of ongoing treatment plan goals.
	• **Timeframe:** Within 30 calendar days from beneficiary's admission to treatment

A. Medical record contains evidence that the ongoing treatment plan meets Title 22 requirements.	The Ongoing Treatment Plan must be: • Completed with 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.

III. Care Planning Guidelines – Treatment Plans – NTP ONLY

Age/Gender		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 a legibly signed treatment plan during appropriate timeframe.	**1**											
C. Treatment plan is client specific and AOD 7110 compliant.	**1**											
D. Medical record contains evidence that the ongoing treatment plan meets Title 22 requirements.	**1**											

Comments:

Criteria	III. Care Planning Guidelines – Problem Lists – All LOC (except NTP)
A. A problem list is established for each patient	The problem list supports the medical necessity of each service provided.
B. Problem list includes all the required elements	The problem list includes a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through the assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list shall include all of the following, but is not limited to: A diagnosis given by a LPHA. Should include specifiers from the DSM, if applicable. Problems identified by provider acting within their scope of practice, if any. Problems or illness provided by client or significant support person, if any. Name and title of provider who identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.
C. Problem list is updated in a reasonable time frame	Any problems identified during a subsequent intervention may be added to the problem list. Problems should be updated on an ongoing basis when there is a relevant change. Provider is required to update when problems change and in a reasonable time.

III. Care Planning Guidelines – Problem Lists – All LOC (except NTP)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. A problem list is established for each client	**1**											
B. Problem list includes all the required elements	**1**											
C. Problem list is updated in a reasonable time frame	**1**											

Comments:

Criteria	IV. Treatment Services Reviewer Guidelines
A. Counseling session attendance is 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
B. 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 3 days of the session** 6) Identifies if the service was in-person, telephone or telehealth 7) Location of service and how confidentiality was maintained (if provided in the community) is clearly documented 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. 9) For Crisis services, documentation must be completed within 24-hours of incidence.
C. There is evidence of at least two Evidence Based Practices (EBPs) being used and documented in the progress notes	Intergovernmental Agreement Exhibit A, Attachment I Providers will implement and deliver to fidelity 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. • **Trauma-Informed Treatment**: Services must take into account an understanding of trauma, and place priority on trauma survivor's safety, choice, and control. • **Psycho-Education:** Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf. • **Relapse Prevention:** A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use disorder treatment.

IV. Treatment Services (Continued)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Counseling session attendance is appropriately documented in the chart.	**1**											
B. Progress notes contain the minimum required documentation according to Title 22 and AOD 7100b.BHIN 23-068												
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 3 days of the session**	**1**											
6) Identifies if the service was in-person, telephone or telehealth	**1**											
7) Location of the service and how confidentiality was maintained (if provided in the community) is clearly documented	**1**											
C. There is evidence of at least two Evidence Based Practices (EBPs) being used.	**1**											

Comments:

Criteria	IV. Treatment Services Reviewer Guidelines (Continued)
H. Medical record contains evidence of the required number of monthly counseling sessions.	Per **Title 22 and AOD standards:** Outpatient - two individual or group counseling sessions each month Intensive Outpatient – progress note for each session Residential –daily When applicable, the progress notes must contain dates and duration of group counseling sessions and have to be signed within 3 days There is evidence of the required number of counseling hours for each LOC. (OP 9 hours or less a week, IOP more than 9 hours a week, Residential: WM: NTP
I. 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.
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. Medical record contains evidence of provider coordination of care	Both the discharging and admitting PROVIDER agencies shall ensure the transition to appropriate LOC. This may include a step-up or step-down in DMC-ODS services. Care coordinators shall provide warm hand-offs and transportation to the new LOC when medically necessary. Provider Agencies shall ensure transitions to other LOCs occur no later than 10 days from the time of assessment or reassessment with no interruption of current treatment services 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).

IV. Treatment Services (Continued)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
H. Medical record contains evidence of the required number of monthly counseling sessions.	**1**											
I. Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps.	**1**											
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.. Medical record contains evidence of provider coordination of care to ensure smooth transitions between LOCs	**1**											

Comments:

Criteria	V. Discharge Services Reviewer Criteria
A. Discharge plan or Discharge Summary is documented in the chart	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 patient 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 patient and shall be documented in the patient's record. **This is N/A if the provider loses contact with the client.**
C. Discharge plan or summary shall include the following elements.	This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client. 3 documented attempts of outreach to client within 30 days of last visit. According to **AOD 7120 b. ,** A discharge summary shall include the following elements: 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.

IV. Discharge Services

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Discharge plan or Discharge Summary is documented in the chart	**1**											
B. The discharge plan is signed by both the patient and the counselor	**1**											
C. Discharge plan or summary shall include the following elements: elements												
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 discharge summary signed by counselor and client	**1**											
7) Transfers and referrals	**1**											
8) Client's comments	**1**											
9) Beneficiary's prognosis	**1**											
10) 1 Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.	**1**											
11) Medication needs were addressed in the discharge planning	**1**											

Comments:

Criteria	VI. Care Coordination Reviewer Criteria
A. Care coordination shall be provided in conjunction with all levels of treatment.deemed necessary	Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.
B. Care coordination services shall include one or more of the component listed (Medical, Mental Health, Ancillary services, Housing, Children's Services, Social Services)	- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions. - Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers. - Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
C. Clinical Peer to Peer Consultation must be documented with a progress note	Clinician Consultation Services consist of LPHAs, such as addiction medicine physicians, licensed clinicians, addiction Psychiatrists, or clinical pharmacists, to support the provision of care. Clinician Consultation is not a direct service provided to beneficiaries. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries.

VI. Care Coordination **Automatic CAP if no or N/A**

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Care coordination shall be provided in conjunction with all levels of treatment deemed necessary	**1**											
B. Care coordination services shall include one or more of the component listed (Medical, Mental Health, Ancillary services, Housing, Children's Services, Social Services)	**1**											
C. Clinical Peer to Peer Consultation must be documented with a progress note	**1**											

Comments:

Criteria	VI. Residential Reviewer Criteria Only if Applicable
A. Medical record contains evidence of prior authorization for services.	Residential Treatment requires a Prior Authorization for services.
B. Evidence of multidimensional LOC assessment within 72 hours of admission is present	Evidence of multidimensional LOC assessment is completed within 72 hours of admission is present
C. There is oversight of self-administered medications.	There is documentation present in the chart that illustrates oversight of patient's taking their medication.
D. Medical record contains documentation of a TB test, results, and services offered.	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. It is mandatory for Tuberculosis services to be offered with a diagnosis of Tuberculosis (TB).
E. 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. Residential

Age/Gender		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. Evidence of multidimensional LOC assessment within 72 hours of admission is present	**1**											
C. There is oversight of self- administered medications.	**1**											
D. Medical record contains documentation of a TB test performed, results, and services offered with a diagnosis of TB	**1**											
E. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 30 days	**1**											

Comments:

Criteria	VII. Perinatal/Family Criteria – Only if Applicable
A. Relevant services offered to perinatal patients or clients with families.	1) Mother/child/ family rehabilitative services. 2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant. 3) Educational/vocational training and life skills resources 4) TB and HIV education and counseling 5) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding (d) Parenting skills-building and child development information 6) Child care is offered for women to receive primary medical care services gender-specific treatment services.
B. Daycare facilities are available to Outpatient Perinatal Patients. .	In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment Program provides/arranges for therapeutic interventions for the children of the women receiving SUD treatment services to address the child's: i. Developmental needs; ii. Sexual abuse; iii. Physical abuse; and Neglect
C. Perinatal/Pediatric Patient Care	Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.
E. Interim services have been offered	If client waited more than 48 hours for treatment, indication of the offering of interim services and the outcome of that offering is included in the patients chart
F. IVDU Interim services have been offered	If the patient uses needles, documentation that the patient received expedited admission within 14 days after the request or within 120 days if interim services were provided.
G. Transportation have been offered/provided	Evidence of transportation provided to perinatal, postnatal, or well child appointments indicated within chart
H. Medical record contains proof of pregnancy and/or delivery for perinatal patients.	

VII. Perinatal/Family Criteria – Only if Applicable

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Relevant services offered to perinatal patients or clients with families.	**1**											
B. Daycare facilities are available to Outpatient Perinatal Patients.	**1**											
C. Perinatal/Pediatric Patient Care	**1**											
E. Interim services have been offered	**1**											
F. IVDU Interim services have been offered	**1**											
G. Transportation have been offered/provided	**1**											
H. Medical record contains proof of pregnancy and/or delivery for perinatal patients.	**1**											

Comments:

If more than one Reviewer, both must sign here.

Reviewer 1 Signature: _____ Reviewer 2 Signature: _____

Reviewer 1 Name: _____ Reviewer 2 Name: _____

Reviewer 1 Title: _____ Reviewer 2 Title: _____

Reviewer Comments/Notes: