QUALITY ASSESSMENT REVIEW WORKSHEET

INITIAL REVIEW

Program ______________________ Admission Date _________________ DMC Billing began Date __________ Date of Review _________________	____ ODF ____ IOT ____ Initial Review ____ Re-admission ____ D/C or Transfer out	CLIENT I.D. ___________________________________ STATE I.D. ___________________________________ Primary Counselor's Name: _______________________

NOTE: All items must have a √ or N/A. If an item is missing, circle the line and identify corrective action in bottom section.

INTAKE

___ Diagnosis Determination Note (Therapist, PA, NP, or MD signed)
Date signed: _______ (Within 30 days)
___ Perinatal / EPSDT Eligibility
___ Intake Screening Form
___ Drug History or ASI
___ Client Assessment or ASI
___ SanWITS completed (Medi-Cal beneficiary?)
___ Financial Form

CONSENT FORMS

___ Release of Information
___ Treatment consent
___ Program Rules & Regulations
___ Follow-up Consent
___ Client Rights (including Fair Hearing Rights)

PHYSICAL

___ Health Questionnaire Complete
___ MD Reviewed; Date MD signed Physical Dir. Form: _______
Exam/Lab work: ( ) ordered ( ) recommended
___ Follow-up on Medical orders &/or recommendations in file
(Letter to client)
___ Medical problems adequately addressed on TX plan/notes
(e.g.: Physical Exam needed, dental, dual dx, TB medication, Hep follow-up, Pregnancy, etc.)

TREATMENT PLAN(S) TIMELINE

Initial Treatment Plan Development Date: __________***
___ Initial Plan developed within 30 days of admission?
Date physician signed Initial TX Plan: ___________
___ MD signature within 15 days?
(If either date is late, see disallowances below)
___ DSM Dx and ICD-10 Code(s) on plan: # ________________

TREATMENT PLAN(S)

___ TX Goals appropriate to client's stage in treatment
___ Long/Short Term Goals & Target dates identified
___ Action Steps measurable & attainable
___ Type of counseling identified in Action Steps
___ Frequency of Counseling is identified in Action Steps
(Minimum = 2 times monthly)

DISCHARGE

Date of last contact (SanWITS D/C date): __________________
Circle: DC Plan or DC Summary; Date completed: __________
___ Discharge SanWITS completed ____10 Day Notice

PROGRESS NOTES

___ Monthly DMC Eligibility Reports in file
___ Progress Notes address ALL problems on TX Plan
___ P Notes document CLT progress toward TX Plan goals
___ Each billing has acceptable documentation
___ Multiple 2nd Service Billings in File
___ ADP 7700 Present

QAR DETERMINATION

___ Full Compliance
___ Corrective Action Required - See Below
___ Approved Discharge

UPCOMING REVIEW DATES

____________ Next Extension Review Date (3 months from now)
____________ Next Stay Review Date (6 months from admit date)
____________ Check this line if Discharge Review completed today

DMC DENIALS ☐ No Denials noted in this chart

A State auditor would probably deny DMC funding from __________ through ____________**.** # Visits denied ________
List the dates of visits that would be denied in a State audit:____
List reason(s) for denied visits ____

CORRECTIVE ACTION REQUIRED (Title 22 related)

☐ **Please give letter to client w/MD orders/recommendations**

QAR COMMENTS & RECOMMENDATIONS:

☐ **Please follow up with client regarding medical tests (letter has already been given to client & is in file)**

QA Reviewer Signature **Date**

Second QA Reviewer Signature **Date**