Confidential QM Report
COSD DMC-ODS Plan
Substance Use Disorder Outpatient Services
Fiscal Year 20-21

SUD MEDICAL RECORD REVIEW SUMMARY

Program Name:		**Reviewer:**		**COR:**	
Legal Entity:		**DMC Certification #**		**Contract #**	
Billing Review Period:	to	**Review Date:**		**# Records Reviewed:**	0
Program Enrollment:				**# Clients at Program:**	

1. Program has written P&Ps for the following:						**Comments:**
A. Program Integrity/Paid Claims Verification	**Yes**		**No**			
B. Assessment	**Yes**		**No**			
C. Internal QI/QM	**Yes**		**No**			
D. Monitoring/Supervision of EBP	**Yes**		**No**			
E. Monitoring/Supervision of ASAM	**Yes**		**No**			
F. Medication monitoring (storage, self-administration)	**Yes**		**No**			
G. Medical Director's P&Ps	**Yes**		**No**			
H. Relapse Plan	**Yes**		**No**			
I. Admission and readmission criteria (DSM diagnosis, use of alcohol/drug of abuse, physical health status, documentation of social and psychological problems, ASAM LOC determination, and referral process for client's not meeting admission criteria)	**Yes**		**No**			
J. Providing translation services to client's whose preferred language is other than English; Limited English Proficieny posters in all 6 threshold languages are posted.	**Yes**		**No**			
2. Program is following written P&Ps	**Yes**		**No**			
3. Grievance/Appeal information available to clients in all threshold languages and posted	**Yes**		**No**			
4. Forms/self-addressed and postage paid envelopes for Grievance/Appeal are easily accessible to clients without need for asking.	**Yes**		**No**			
5. Program rules, expectation, and regulations posted or provided	**Yes**		**No**			
6. Data Entry Standards met	**Yes**		**No**			
7. Program has their Notice of Privacy Practices posted in an area that is visible and accessible to all clients.	**Yes**		**No**			
8. Does program staff have copies or electronic access to the current version of following?						
A. SUDPOH	**Yes**		**No**			
B. SUDURM	**Yes**		**No**			
C. DHCS and BHS Billing Manuals	**Yes**		**No**			
D. DHCS AOD Certification Standards	**Yes**		**No**			
E. CalOMS Manuals	**Yes**		**No**			
F. Community Resource List for clients	**Yes**		**No**			

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Overall Result	QIP Required?	Recovery of Payment Rate	
	#DIV/0!	#DIV/0!	**Overall Result:** Percentage represents number of yes response(s) divided by the total number of yes and no response(s). N/A responses are not included. **Recovery of Payment Rate:** The number of disallowed services divided by the total number of services reviewed. The recovery of payment rate does not include non-billable services or services that can be edited/corrected/claimed. Recovery of payments are based on the DMC-ODS Intergovernmental Agency Agreement (IA) Standards.

Quality Improvement Plan (QIP) Requirements: Refer to the comments section at the bottom of each category for QM Reviewer feedback.

1. A QIP is required if the Overall Result is below 90% or if disallowance rate exceeds 5%. The QIP shall include the Billing Summary Form. A QIP may also be requested at the discretion of the QM Specialist for any significant deficiencies/trends identified in the review.
2. If the Overall Result is below 80%, a second SUD MRR will occur after a period of time (3 months) that program has been able to implement its quality improvement plan.
3. Any services listed on the Billing Summary Form shall be corrected on the Billing Summary Form and submitted to QM within 14 days of receipt of SUD MRR.
4. Quality Improvement Plans are due to the QM Unit within 14 days of the date program is notified of required QIP.

Prior year SUD MRR Results and Quality Improvement Plan Comments:

1.
2.
3.
4.
5.

Commendable Efforts:

1.
2.
3.
4.
5.

Continuous Quality Improvement Recommendations:

1.
2.
3.
4.
5.

Confidential QM Report

COSD DMC-ODS Plan
Medical Record Review for
Outpatient SUD Services

REVIEW DATE:	1/0/1900	**CHART NUMBER:**		**BILLING REVIEW PERIOD:**	1/0/1900	**TO**	1/0/1900
DMC CERTIFICATON #:	0	**PROGRAM NAME:**	0	**UNIQUE CLIENT NUMBER:**		**ADMISSION DATE:**	
LOC AT START OF REVIEW PERIOD:		**LOC AT END OF REVIEW PERIOD:**		**# OF SERVICES REVIEWED:**		**DISCHARGE DATE:**	

	INTAKE/ASSESSMENT	REFERENCE	Yes	No	N/A
1	The Initial Level of Care Assessment completed with all signatures upon intake (within 7 calendar days).	IA: DMC-ODS, Attachment I, III, PP, 10, ii, a			
2	Initial Level of Care Assessment form documentation supports the Recommended and the Actual Level of Care designated.	IA: DMC-ODS, Attachment I AI, III, B, 2, ii, b; IA: DMC-ODS, Attachment I AI, III, F, 3, iv.			
3	Initial Level of Care Assessment form documents a provisional DSM-5 diagnosis.	IA: DMC-ODS, Attachment I, III, B, 2, ii, a, i			
4	Initial Level of Care Assessment form documents client's preferred language.	IA: DMC-ODS, Exhibit A, Attachment I A1, II, B, 2, vii-xiii.			
5	If the Initial LOC Assessment is completed by a SUD counselor, documentation of a Face to Face visit with a LPHA/MD in the chart.	IA: DMC-ODS, Exhibit A, Attachment I A1, III, B, 2, iv			
6	Diagnosis Determination Note meets standards (LPHA documents the basis for DSM-5 diagnosis, and legibly printed name, adjacent signatures and date within 30 days of admission. (Day of admit + 29 days)	Title 22: Drug Medi-Cal Substance Use Disorder Services. 51341.1, h, 1, A, v, a IA: DMC-ODS, Attachment I, III, PP, 10, i, a Minimum Quality Drug Standards for DMC/SABG			
7	Risk Assessment and Safety Management Plan (or HRA for admits prior to 8/1/19) completed upon admit.	COSD Standard			
	Assessments (Initial LOC Assessment, Risk Assessment, Health Questionnaire, ASI/YAI, CalOMS, etc.) shall include the following:				
8	Drug/alcohol use history	Minimum Quality Drug Standards for DMC/SABG			
9	Medical history	Minimum Quality Drug Standards for DMC/SABG			
10	Family history	Minimum Quality Drug Standards for DMC/SABG			
11	Psychiatric/psychological history	Minimum Quality Drug Standards for DMC/SABG			
12	Social/recreational history	Minimum Quality Drug Standards for DMC/SABG			
13	Financial status/history	Minimum Quality Drug Standards for DMC/SABG			
14	Educational history	Minimum Quality Drug Standards for DMC/SABG			
15	Employment history	Minimum Quality Drug Standards for DMC/SABG			
16	Criminal history, legal status	Minimum Quality Drug Standards for DMC/SABG			
17	Previous SUD treatment history	Minimum Quality Drug Standards for DMC/SABG			
	Intake/Assessment Comments:				

	CONSENTS/CONFIDENTIALITY	REFERENCE	Yes	No	N/A
18	Consent for treatment signed and dated prior to treatment services being provided.	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 8, iii Minimum Quality Drug Standards for DMC/SABG			
	Consents/Confidentiality Comments:				

	HEALTH/MEDICAL	REFERENCE	Yes	No	N/A
19	For perinatal programs, pregnant and postpartum client chart documentation substantiates pregnancy and last day of pregnancy.	Title 22 51341.1, g, 1, A, iii			
20	There is documentation to support that the physician has reviewed the physical examination results, with typed or legibly printed name, signature and date (signature adjacent to typed or legibly printed name).	IA: DMC-ODS Exhibit A, Attachment I, III , PP, 11, iii			
21	If drug screening is performed, the results are documented in the client's record.	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 8, viii Minimum Quality Drug Standards for DMC/SABG			
22	Health Questionnaire is completed upon admission as required and signed by the client and reviewing staff.	AOD Certification Standards: 7020			
	Health/Medical Comments:				

	TREATMENT PLANNING	REFERENCE	Yes	No	N/A
23	Initial Treatment Plan shall include typed or legibly printed name adjacent to signature, date of signature of counselor, client (or reason why client's signature not obtained) and medical director/LPHA and was completed within 30 calendar days of admission. (Day of admit + 29 days)	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i, b, I; Title 22 51341.1, h, 2, A, I, a-I; Minimum Quality Drug Standards for DMC/SABG			
24	Updated treatment plans shall include typed or legibly printed name adjacent to signature, date of signature of counselor, client (or reason why client's signature not obtained) and medical director/LPHA and was completed within 90 calendar days of counselor's signature on last treatment plan. (Counselor signature date + 89 days)	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, ii, a			
25	ASAM Level of Care Recommendation forms are complete as part of the initial and updated treatment planning process.	COSD Standard			
26	The current ASAM LOC Recommendation form documentation supports the Recommended and Actual Level of Care designated.	COSD Standard			
27	Updated treatment plans accurately reflect the client's progress or lack of progress in treatment.	Minimum Quality Drug Standards for DMC/SABG			
28	Treatment plans are individualized to the client based upon information obtained in the intake/assessment process.	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i			
29	Each treatment plan includes a problem statement for all problems identified through the assessment whether addressed or deferred.	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i, a, i, 1; Minimum Quality Drug Standards for DMC/SABG			
30	Each treatment plan includes goals to address each problem statement (unless deferred). Goals and action steps are specific, achievable, and measurable.	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i, a, i, 2; Minimum Quality Drug Standards for DMC/SABG			
31	Each treatment plan includes action steps to meet the goals that include who is responsible (provider and/or client) for the action and the target date for completion.	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i, a, i, 3; Minimum Quality Drug Standards for DMC/SABG			
32	Each treatment plan includes frequency for all interventions/services.	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i, a, i, 5			
33	Each treatment plan includes the client's SUD DSM-5 diagnosis(es) as documented on the Diagnosis Determination Note. (If more than one SUD diagnosis, tx plan must include all as documented on the DDN).	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i, a, i, 7			
34	Treatment plan covering the review period includes a goal for all health needs (physical/dental) identified at intake/assessments/reassessments/physical exam results, if applicable.	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i, a, i, 8			
35	Treatment plan includes the goal of obtaining a physical exam until that goal is obtained (if physical exam requirement is not met by physician reviewing most recent physical exam-must be within 12 months of admit; or, physician, NP, or PA performed a physical within 30 days).	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 12, i, a, i, 8			
	Treatment Plan Comments:				

	PROGRESS NOTES	REFERENCE	Yes	No	N/A
36	For each service claimed, the LPHA or counselor who conducted the service completed a progress note with adjacent typed/legibly printed name, signature and date within 7 calendar days of service. (Day of service + 6 days)	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 14, I, a, i			
37	Progress note summaries include topic and description of service (provider support and interventions, description of client's progress on treatment plan problems, goals, action steps, objectives, and/or referrals. client's ongoing plan including any new issues)	IA: DMC-ODS Exhibit A, Attachment I, III, PP, 14, I, a, ii Minimum Quality Drug Standards for DMC/SABG			
38	Progress notes include the correct service code, date of service, including start and end times and duration of travel or documentation time, if applicable.	IA, Exhibit A, Attachment I: III, PP, 17			
39	Time billed is equal to time documented and substantiated in documentation.	IA, Exhibit A, Attachment I: III, BB, 2, i			
40	Progress note narrative for clinical services reflects utilization of Evidence Based Practices of Motivational Interviewing (MI) within the treatment session or group with client.	IA, Exhibit A, Attachment I: III, AA,3, iii			
41	Progress note narrative for clinical services reflects utilization of Evidence Based Practices of Relapse Prevention (RP) within the treatment session or group with client.	IA, Exhibit A, Attachment I: III, AA,3, iii			
42	Progress notes reflect clinical contact as appropriate for determined ASAM level of care (less than 9 hours a week for adult OS/6 hours a week for adolescent OS; between 9-19 hours a week for adult IOS/6-19 hours a week for adolescent IOS).	IA, Exhibit A, Attachment I: III, O, 1 IA, Exhibit A, Attachment I: III, P, 1			
43	If services were provided in the community, progress notes document the location and how the provider ensured confidentiality.	IA, Exhibit A, Attachment I: III, PP, 14, I, a, ii, 5.			
44	All clinical and patient education groups meet size standard (2 - 12 participants).	IA, Exhibit A, Attachment I: IV, A, 44			
45	There is a group sign-in sheet for each group service provided to the client.	IA Exhibit A III. PP. 13			
	Each group session has a sign-in sheet that includes the following:				
46	Adjacent typed/legibly printed name and signature of the LPHA or counselor conducting the session and date. The date of signature must be the same day as the group service.	IA, Exhibit A, Attachment I: III, PP, 13			
47	The date of the session and start and end time of the session	IA, Exhibit A, Attachment I: III, PP, 13			
48	The topic of the session	IA, Exhibit A, Attachment I: III, PP, 13			
49	A typed/legibly printed list of the client's first and last names and signatures of each client that attended the session	IA, Exhibit A, Attachment I: III, PP, 13			
	Progress Notes Comments:				

	CONTINUING SERVICES JUSTIFICATION	REFERENCE	Yes	No	N/A
50	Continuing Services Justification (aka Stay Review Justification) completed no sooner than five months and no later than six months after client's admission to treatment (or date of completion of the most recent justification).	IA, Exhibit A, Attachment I: III, PP, 15			
51	The LPHA has documented medical necessity for continued services at the same level of care, or recommended step-down or step-up in level of care.	IA, Exhibit A, Attachment I: III, PP, 15			
	Documentation of the Continuing Services Justification includes consideration of all the following:				
52	Client's personal, medical, and substance use history	IA, Exhibit A, Attachment I: III, PP, 15			
53	Documentation of the client's most recent physical exam	IA, Exhibit A, Attachment I: III, PP, 15			
54	The client's progress notes and treatment plan goals	IA, Exhibit A, Attachment I: III, PP, 15			
55	The LPHA's or counselor's recommendations	IA, Exhibit A, Attachment I: III, PP, 15			
56	The client's prognosis	IA, Exhibit A, Attachment I: III, PP, 15			
57	If the LPHA determines continuing treatment services are not medically necessary, the documentation reflects following required discharge and warm handoff processes.	IA, Exhibit A, Attachment I: III, PP, 15			

	Continuing Services Justification Comments:				
	DISCHARGE	**REFERENCE**	Yes	No	N/A
58	LPHA or counselor completed a discharge plan for each planned discharge within 30 calendar days prior to the last scheduled treatment service with client. (Discharge Plan includes typed or legibly printed name, signature, and signature date of client and LPHA/Counselor. The signatures shall be adjacent to the typed or legibly printed name.)	IA, Exhibit A, Attachment I: III, PP, 16			
59	There is documentation of care coordination/warm hand off at discharge to another level of care or recovery services.	COSD Standard			
	Discharge plan includes:				
60	Description of client's triggers	IA, Exhibit A, Attachment I: III, PP, 16			
61	A plan to avoid relapse when confronted with these triggers	IA, Exhibit A, Attachment I: III, PP, 16			
62	A support plan	IA, Exhibit A, Attachment I: III, PP, 16			
63	Documentation indicates the client was given a copy of the discharge plan.	Minimum Quality Drug Standards for DMC/SABG			
64	LPHA or counselor completed a discharge summary for each client within 30 calendar days of the date of the last face-to-face or telephone contact with the client.	IA, Exhibit A, Attachment I: III, PP, 16			
	Discharge summaries include all of the following:				
65	The duration of the client's treatment as determined by the dates of admission to and discharge from treatment	IA, Exhibit A, Attachment I: III, PP, 16			
66	The reason for discharge	IA, Exhibit A, Attachment I: III, PP, 16			
67	A narrative summary of the treatment episode	IA, Exhibit A, Attachment I: III, PP, 16			
68	The client's prognosis	IA, Exhibit A, Attachment I: III, PP, 16, iii.b.iv			
	Discharge Comments:				
	FINANCIAL/BILLING	**REFERENCE**	Yes	No	N/A
69	Initial and monthly DMC eligibility is documented in the chart.	IA, Exhibit A, Attachment I: III, BB, 2, ii			
	Financial/Billing Comments:				