QUALITY ASSURANCE REVIEW WORKSHEET

INITIAL REVIEW

Number of Service Billings _____

Program _____	____ OS ____ IOS ____ Recovery Svcs	CLIENT FILE#: _____
Admission Date _____	____ Initial Review	STATE I.D. _____
DMC Billing began Date _____	____ Re-admission	Primary Counselor's Name: _____
Date of Review _____	____ D/C or Transfer out	

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

___ Monthly DMC eligibility reports in file
___ Perinatal / EPSDT Eligibility
___ Initial Level of Care Assessment (or Intake Screening Form with ASAM Criteria prior to July 1, 2018)
___ SanWITS completed (Medi-Cal indicated)
___ Financial Form

CONSENT FORMS

___ Release of Information (if applicable)
___ Treatment consent
___ Program Rules & Regulations
___ Notice of Privacy Practices
___ 42 CFR Written Summary Requirements
___ Personal Rights at An AOD Certified Program

ASSESSMENTS

___ ASI/YAI with **all** sections; Date completed _____
___ ASAM Level of Care Recommendation form completed
Date completed: _____
___ Diagnosis Determination Note (LPHA or MD signed)
Date signed: _____ (Within 30 days)

PHYSICAL

___ Health Questionnaire completed
___ 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, vision, 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-5 Dx on plan: # _____
___ Initial TX Plan completed with ASAM dimensions
___ TX Goals appropriate to client's stage in treatment
___ Action Steps measurable & attainable
___ **Type** and **Frequency** (Minimum = 2 times monthly) of counseling identified

PROGRESS NOTES

___ All problems on TX Plan are addressed in Progress Notes
___ PN document CLT progress toward TX Plan goals
___ Each billing has a PN signed & completed within 7 days

DISCHARGE

Date of last face-to-face contact (SanWITS D/C date): _____
___ DC Summary completed? Completed w/in 30 days? ☐ yes ☐ no
___ DC Plan completed? Completed w/in 30 days? ☐ yes ☐ no
___ Discharge SanWITS completed

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 _____. # Services denied _____

List the dates of visits that would be denied in a State audit:_____

List reason(s) for denied visits: _____

CORRECTIVE ACTION REQUIRED

☐ **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**