QUALITY ASSURANCE REVIEW WORKSHEET

EXTENSION/STAY/DISCHARGE REVIEW

Number of Service Billings _____

Program _____ Admission Date _____ DMC Billing began Date _____ Date of Review _____ Date of Last Review _____ Date MD signed last Stay Review:_____ Stay Review Due Date: _____	____ OS ____ IOS ___ Recovery Svcs ____ Extension Review ____ Stay Review ____ D/C or Transfer out ____ Last Corrective Action complete	CLIENT FILE#: _____ 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.

MEDICAL/HEALTH REVIEW

Follow-up on MD Orders & Recommendations in chart? ☐ yes ☐ no ☐ n/a (Client notified?)

Client cleared for participation? ☐ yes ☐ no

STAY REVIEW

Has QAR reviewed latest Stay Review? ☐ yes ☐ no ☐ n/a (check previous Review forms for accurate dates)

Stay Review Justification present & signed by MD? ☐ yes ☐ no ☐ n/a

Date MD Signed latest Stay Review _____

(See disallowances below if MD signed later than 6 months)

LAST QAR FORM

Corrective Action complete: ☐ yes ☐ no ☐ n/a

Comments/Recommendations incorporated in charting? ☐ yes ☐ no ☐ n/a

Note: Corrective Action must be completed, however, not all comments or recommendations must be adhered to. Check with QAR Chair if you have questions.

PROGRESS NOTES

___ **Monthly DMC Eligibility Reports in file**
___ All problems on TX Plan are addressed in Progress notes
___ PN document CLT progress toward Tx Plan goals
___ Each billing has a PN signed and completed within 7 days (if not, see disallowances below)

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

TREATMENT PLAN(S) TIMELINE

Development Date of **last** Tx Plan reviewed (See **last** QAR Review Form for this date): _____

Tx Plan due date(s) (90 days from last Tx Plan(s)):

A)_____ & **B**)_____

Review of Tx Plan(s) needed? ☐ yes ☐ no (if no, skip to PN section)

Updated Tx Plan(s) development date(s):

A)_____ & **B**)_____

Updated Tx plan(s) developed in timely manner? ☐ yes ☐ no

Date MD signed Tx Plan(s) **A**) _____ & **B**) _____

MD signature within 15 days? yes ☐ no ☐ & ☐ yes ☐ no

(If either date is late, see disallowances below)

DSM-5 Dx on all Tx plan(s): # _____

Updated Tx Plan covers Physical Exam: yes ☐ no ☐ n/a ☐

Tx Goals appropriate to client's stage in Tx: ( ) & ( )

Action Steps measurable & attainable: ( ) & ( )

Type of counseling & Frequency of Counseling ( ) & ( ) are identified (min = 2 times/month):

Updated ASAM Level of Care Recommendation form development date: _____

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 or last MD signature on Stay Review)
_____ Check this line if D/C review completed today

DMC DENIALS

☐ No Denials noted in this chart

A State auditor would probably deny D/MC 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**