Core Scoring Grid
GENERAL
The record is accurate and clearly legible to someone other than the writer.
All entries in the record identifies the name of member.
Each record includes member's social security number. BHSP
Each record includes member's address. BHSP
Each record includes employer and/or school, if applicable. BHSP
Each record includes home, school, and/or work telephone numbers. BHSP
Each record includes emergency contact information.
Each record includes date of birth. BHSP
Each record includes gender. BHSP
For members 0 to 17 documentation of authorized representative is included in the record, and proof of authorized representative, if applicable. BHSP

For members 0 to 17, there is evidence that services are in context of the family.
For members 0 to 17, there is evidence of ongoing communication with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.
For members 0 to 17, there is evidence of ongoing coordination with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.
Each member has a separate record.
All entries and forms completed by staff in member records include the name of the person making the entry.
All entries and forms completed by staff in member records include the name of the person making the entry's functional title, applicable educational degree and/or professional license of the person making the entry.
All entries and forms completed by staff in member records include full date of documentation.

All entries and forms completed by staff in member records include signature (including electronic signature for EMR systems).
MEMBER RIGHTS
There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian. BHSP/LMHP
For members over the age of 18 years of age and older, the member is given information to create an advance directive or refusal is documented.
There is evidence of the member being given information regarding member's rights to confidentiality. BHSP
TELEMEDICINE/TELEHEALTH ****LMHPs practicing independently & CMS has approved telehealth for CPST effective 5/1/23.**
Telemedicine use documented, if applicable.
The member's record includes informed consent for services provided through the use of telehealth
If assessments and/or re-evaluations are completed via telecommunication system, LDH has approved utilizing telemedicine/telehealth for conducting assessments conducted by licensed mental health practitioners.
For telemedicine/telehealth services, there is consent signed by the recipient or authorized representative in the record authorizing recording of the session.
If utilizing telemedicine/telehealth services, the consent form includes the rationale for using telemedicine/telehealth in place of in-person services
If utilizing telemedicine/telehealth services, the consent form includes the risks of telemedicine/telehealth, including privacy related risks.

If utilizing telemedicine/telehealth services, the consent form includes the benefits of telemedicine/telehealth, including privacy related risks.
If utilizing telemedicine/telehealth services, the consent form includes possible treatment alternatives.
If utilizing telemedicine/telehealth services, the consent form includes risks of possible treatment alternatives.
If utilizing telemedicine/telehealth services, the consent form includes benefits of possible treatment alternatives.
If utilizing telemedicine/telehealth services, the consent form includes the risks of no treatment
If utilizing telemedicine/telehealth services, the consent form includes the benefits of no treatment
For telemedicine/telehealth services, there is evidence in the record of verification of recipient's identity, if needed.
For telemedicine/telehealth services, when possible (i.e. at the next in person treatment planning meeting), providers must have the recipients sign all documents that had verbal agreements previously documented.

For telemedicine/telehealth services, there is evidence in the record of a back-up plan (e.g., phone number where recipient can be reached) to restart the session or to reschedule it, in the event of technical problems.
For telemedicine/telehealth services, there is evidence in the record of a safety plan that includes at least one emergency contact and the closest ER location, in the event of a crisis.
Progress notes document specifically if service was provided through Telemedicine/Telehealth. (outpatient services)
For telemedicine/telehealth services, there is evidence in the record the member was informed of all persons who are present.
For telemedicine/telehealth services, there is evidence in the record the member was informed of the role of each person.
For telemedicine/telehealth services, there is evidence of documentation if recipient refused services delivered through telehealth or request that services be delivered in-person, the provider must provide an in-person service or refer to an equally qualified licensed practitioner.
For telemedicine/telehealth services, providers need the consent of the recipient and/or the recipient's parent or legal guardian (and their contact information) prior to initiating a telemedicine/telehealth service with the recipient if the recipient is 17 years old or under.
INITIAL EVALUATION
An initial/Annual assessment is in the record.

An initial/Annual assessment is completed by a licensed mental health professional.
A member can sign the assessment electronically.
For members 0 to 17 there is evidence the Legal Guardian is involved in the assessment.
Presenting problem(s) are identified.
An initial primary treatment DSM diagnosis is present in the record. BHSP
The reasons for admission or initiation of treatment are appropriate to services being rendered.
A complete mental status exam is in the record, documenting the member's affect.
A complete mental status exam is in the record, documenting the member's speech.
A complete mental status exam is in the record, documenting the member's mood.
A complete mental status exam is in the record, documenting the member's thought content.
A complete mental status exam is in the record, documenting the member's judgement.
A complete mental status exam is in the record, documenting the member's insight.
A complete mental status exam is in the record, documenting the member's attention or concentration.
A complete mental status exam is in the record, documenting the member's memory.
A complete mental status exam is in the record, documenting the member's impulse control.
The behavioral health treatment history includes family history information.

A behavioral health history is in the record, including any previous providers.
A behavioral health history is in the record, including treatment dates, if applicable.
A behavioral health history is in the record, including treatment modality, if applicable.
A behavioral health history is in the record, including member response, if applicable.
The medical treatment history includes known medical conditions. BHSP
The medical treatment history includes allergies and/or adverse reactions and dates. BHSP
The medical treatment history includes providers of previous treatment, if applicable.
The medical treatment history includes current treating clinicians.
The medical treatment history includes current therapeutic interventions and responses.

The medical treatment history includes family history.
Current medications are listed (PH & BH).
Prescriber of current medications are listed (PCP & BH).
Medication dosage is listed.
Medication frequency is listed.
Medication start date is listed.
Response to medication and other concurrent treatment (successful/unsuccessful) is documented.

Prescribed medication problems/side effects are documented, if applicable.
The initial history for members under the age of 21 includes prenatal and perinatal events, if information is available.
The initial history for members under the age of 21 includes a complete developmental history (physical, psychological, social, intellectual and academic).
Assessment of risk includes the presence or absence of **current** suicidal or homicidal risk, danger toward self or others.
Assessment of risk includes the presence or absence of **previous** suicidal or homicidal risk, danger toward self or others.
The record includes documentation of dates of previous suicidal or homicidal behaviors.

The record includes documentation of methods of previous suicidal or homicidal behaviors.
The record includes documentation of lethality of previous suicidal or homicidal behaviors.
Documentation of any abuse the member has experienced.
Documentation of whether the member has been the perpetrator of abuse.
Substance use assessment was conducted.
Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications and nicotine use.
The record documents the presence or absence of relevant legal issues of the member and/or family.

There is documentation that the member was asked about community resources (family, support groups, social services, school based services, other social supports) that they are currently utilizing.
The record documents the assessment of the member's strengths.
The record documents the assessment of the member's needs.
The assessment documents any financial concerns.
The assessment documents any challenges related to transportation.
The member's desired outcomes of treatment are clearly documented in the record.
There is evidence of preliminary discharge planning.
Indication and identification of any standardized assessment tool or comprehensive screening completed (i.e. a PHQ-9, GAD-7) as dictated by diagnosis. BHSP
An initial health screening, such as the Healthy Living Questionnaire or the PBHCI, is included in the record. (Unless directed by the plan, this is for informational purposes and not counted against a provider in the compliance rating.)
TREATMENT PLAN
The treatment plan is in the record. *Based on Most recent tx plan; can review prior tx plan to see progression and updates.

Treatment plan is signed by the member.
Treatment plan is signed by member's guardian, if applicable.
Treatment plan is developed by and signed by treating LMHP including credentials in signature.
Treatment plan signed by caregiver or other treating professionals or paraprofessionals involved in tx team.
Date of treatment plan.
Indication if it is an “initial” or an “updated” treatment plan.
The treatment plan is updated whenever goals are achieved or new problems are identified.
Progress on all goals are included in the update.
Treatment plan is based on the assessment (initial or updated).
Member's strengths are included in the treatment plan.
Member's needs are included in the treatment plan.
Treatment plan utilizes input from the member, family, natural supports, and/or treatment team.

Treatment plan is consistent with assessment.
Treatment plan has individualized long term goals.
Treatment plan has individualized short term goals/objectives.
Treatment plan goals/objectives are specific.
Treatment plan goals/objectives are measurable.
Treatment plan goals/objectives are action-oriented.
Treatment plan goals/objectives are realistic.
Treatment plan goals/objectives are time-limited.
Treatment plan reflects service locations for each intervention
Treatment plan reflects staff providing the intervention
There is evidence the treatment has been revised/updated to meet the changing needs of the member, if applicable. BHSP

Treatment plan reflects services to be provided in the duration.
Treatment plan reflects services to be provided in the frequency.
Individualized Crisis Plan is in the record.
Crisis plan signed by Member and/or member's authorized representative as proof of participation in the development of crisis plan.
Peer Support Services (PSS): Peer support services are person-centered.
Peer Support Services (PSS): Peer support services are recovery focused.
Peer Support Services (PSS): Recovery planning assists members to set goals related to home.
Peer Support Services (PSS): Recovery planning assists members to set goals related to work.
Peer Support Services (PSS): Recovery planning assists members to set goals related to community.
Peer Support Services (PSS): Recovery planning assists members to set goals related to health.
Peer Support Services (PSS): Recovery planning assists members to accomplish goals related to home.

Peer Support Services (PSS): Recovery planning assists members to accomplish goals related to work.
Peer Support Services (PSS): Recovery planning assists members to accomplish goals related to community.
Peer Support Services (PSS): Recovery planning assists members to accomplish goals related to health.
PROGRESS NOTES
There is evidence in the record that, regardless of the originating site, providers must maintain adequate medical documentation to support reimbursement of the visit.
Progress notes reference treatment goals.
Progress note includes sufficient detail to support the length of the contact
Service provider contact telephone number
Documentation of goals/objectives being referenced
Documentation of specific interventions delivered
Documentation of what materials were used when teaching a skill

Documentation of observed behaviors.
Member's response to intervention
All progress notes document clearly who is in attendance during each session (outpatient services).
Services provided to children and youth must include communication and coordination with the family and/or legal guardian/responsible party
Documentation of the services delivered for each client signed by the client or responsible person for services provided in the home or community. BHSP
The progress notes describe progress or lack of progress towards treatment plan goals.

The progress notes document continuous substance use assessment (if applicable).
The progress notes document on-going risk assessments (including but not limited to suicide and homicide).
The progress notes document (including but not limited to suicide and homicide) monitoring of any at risk situations.
Compliance or non-compliance with medications is documented (if applicable).
Progress notes include date of service noted.
Progress notes include begin times of service noted.
Progress notes include end times of service noted.
Progress notes include signature of the person making the entry. If initials are utilized, initials of providers must be identified with correlating signatures.
Progress notes include the functional title, applicable educational degree and/or professional license of the person making the entry.
The progress notes document the dates or time periods of follow up Outpatient Providers appointments.
Provider documents when the member misses appointments, if applicable.

Services documented in the progress note reflect services billed. BHSP
There is evidence of progress summaries in the record.
There is evidence of progress summaries completed at least every 90 days, or more frequently as needed, if applicable.
Progress summaries document the start and end date for the time period summarized.
Progress summaries indicate who participated.
Progress summaries indicate where contact occurred.
Progress summaries indicate what activities occurred.
Progress summaries indicate how the recipient is progressing or lack of progression toward the personal outcomes in the treatment plan.
Progress summaries document any deviation from the treatment plan, if applicable.
Progress summaries document any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and/or treatment plan change, as applicable.
Progress summaries include signature of the person completing the summary. If initials are utilized, initials of providers must be identified with correlating signatures.
Progress summaries include the functional title, applicable educational degree and/or professional license of the person completing the summary.
Progress summaries are dated.
Progress Summary is entered in the member's record when a case is transferred or closed.

Progress summaries shall be signed by the person providing the services.
Peer Support Services (PSS): Peer support services are face-to-face interventions with the member present.
Peer Support Services (PSS): Peer support services may include, but are not limited to utilizing 'lived experience' to translate and explain the recovery process step by step.
Peer Support Services (PSS): Peer support services may include, but are not limited to utilizing 'lived experience' to translate and explain the expectations of services.
Peer Support Services (PSS): Peer Support Services are therapeutic or have programmatic content.
Peer Support Services (PSS): Peer Support Services do not contain recreational, social, or leisure (activities) in nature services.
Peer Support Services (PSS): Peer Support Services documented do not provide transportation.
Peer Support Services (PSS): Peer Support Services do not document general office/clerical tasks as part of rendered services.
Peer Support Services (PSS): Peer Support Services do not document attendance in meetings or sessions without a documented purpose/benefit from the peer's presence in that meeting or session.
CONTINUITY AND COORDINATION OF CARE
Services provided to children and youth must include communication and/or coordination with the primary care physician (PCP).
All coordination with other providers or agencies involved in the youth's treatment must be documented within the record.
The record documents that the member was asked whether they have a PCP.

PCP's name is documented in the record, if applicable.
PCP's address is documented in the record, if applicable.
PCP's phone number is documented in the record, if applicable.
If the member has a PCP, there is evidence of provider attempting or successfully communicating with PCP or there is documentation that the member/guardian refused consent for the release of information to the PCP.
The record documents that the member was asked whether they are being seen by another behavioral health clinician.
Other behavioral health clinician's name is documented in the record, if applicable.
Other behavioral health clinician's address is documented in the record, if applicable.
Other behavioral health clinician's phone number is documented in the record, if applicable.
If the member is being seen by another behavioral health clinician, there is evidence of provider attempting or successfully communicating with primary behavioral health clinician or there is
Provider documents any referrals made to other clinicians, agencies, and/or therapeutic services, if applicable.
Documentation of referrals, if applicable. *Moved to Cont of Care
Release of Information signed or refusal noted for communications with other treating providers, if applicable.
MEDICATION MANAGEMENT (IF APPLICABLE)
Each record indicates each medication name. BHSP
Each record indicates each medication type. BHSP
Each record indicates each medication frequency of administration. BHSP
Each record indicates the person who administered each medication. BHSP
Each record indicates each medication route. BHSP
There is evidence that lab work is ordered, if applicable. BHSP
Each record indicates what medications have been prescribed. BHSP
Each record indicates the dosages of each medication. BHSP
Documentation of member education of prescribed medication.
For members 18 and over, documentation of the member understanding and consenting to the medication used in treatment.

For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.
AIMS (Abnormal Involuntary Movement Scale) performed when appropriate (e.g., member is being treated with antipsychotic medication).
Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs and chronic conditions to document ongoing monitoring. (*Reference list labeled "common Antipsychotics" on later tab)
There is evidence ordered lab work has been reviewed by the clinician ordering the lab work, if applicable as evidenced by date and signature of clinician.
There is evidence of medication monitoring in the treatment record, documenting adherence.
There is evidence of medication monitoring in the treatment record, documenting efficacy.
There is evidence of medication monitoring in the treatment record, documenting adverse effects.
RESTRAINTS AND SECLUSION
Documentation of alternatives/other less restrictive interventions were attempted. ***ONLY PRTF** - HSS PRTF section, 42 CFR G
Documentation of restraint/seclusion order. ***ONLY PRTF**
Documentation of physician notification of restraint. ***ONLY PRTF**
Documentation of member face to face assessment by a physician or physician extender (e.g., PA, NP, APRN) within one hour of restraint initiation/application. ***ONLY PRTF**
Documentation must show evidence of consultation with the physician or physician extender (e.g., PA, NP, APRN) within 24 hours of restraint initiation/application. ***ONLY PRTF**
Documentation of members' parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only). ***ONLY PRTF**
PATIENT SAFETY
If the member was placed on a special watch for harmful behavior, documentation of the appropriate precautions taken and monitoring occurred. BHSP
If the member was a victim of abuse or neglect, documentation of report to the appropriate protective agency and Health Standards, as applicable. BHSP
CULTURAL COMPETENCY

There is evidence that services were appropriate for age of member
There is evidence that services were appropriate to the developmental abilities of member
There is evidence that services were appropriate to the education level of member
Primary language spoken by the member is documented.
Any translation needs of the member are documented, if applicable.
Language needs of the member were assessed (i.e. preferred method of communication), if applicable.
Religious/Spiritual needs of the member were assessed.
Racial needs of the member were assessed.(i.e. oppression, privilege, prejudice…etc.), if applicable.
There is evidence that services are appropriate to individuals of diverse gender identities.
Identified gender needs of the member were incorporated into treatment, if applicable.
Ethnic needs of the member were assessed.
Sexual health related needs were assessed (i.e. sexual identities, sexual orientation, sexual expression, etc..
ADVERSE INCIDENTS
For members 0 to 17, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery. BHSP
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery. BHSP
Documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate. BHSP
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery. BHSP
DISCHARGE PLANNING
Documentation of discussion of discharge planning/linkage to next level of care.
Discharge Summary is entered in the member's record when a case is transferred or closed.
Appointment date and/or time period of follow up with transitioning behavioral health provider documented on the discharge plan. If not, barriers noted, when member is discharged or transitioned to a different level of care.

There is documentation that communication/collaboration occurred with the receiving clinician/program. If not, barriers noted, when member is discharged or transitioned to a different level of care.
PCP appointment date and/or time period of follow up documented if medical co morbidity present. If not, barriers noted, when member is discharged or transitioned to a different level of care.
Medication profile provided to outpatient provider during transition of care. If not, barriers noted, when member is discharged or transitioned to a different level of care.
Medication profile reviewed with member during transition of care, when member is discharged or transitioned to a different level of care.
Course of treatment (the reason(s) for treatment and the extent to which treatment goals were met) reflected in the discharge summary, when member is discharged or transitioned to a different level of care.
A discharge summary details the recipient's progress prior to a transfer or closure, when member is discharged or transitioned to a different level of care.
A discharge summary must be completed within 14 calendar days following a recipient's discharge or transition to a different level of care.

CPG Scoring Grid

Major Depressive Disorder
The provider found sufficient evidence to support the diagnosis of MDD by ruling out medical conditions that might cause depression and/or complicate the treatment.
The provider delivered education about MDD and its treatment to the member, and if appropriate, to the family.
If psychotic features were found, the treatment plan included the use of either antipsychotic medication or ECT, or clear documentation why not.
If MDD was of moderate severity or above, the treatment plan used a combination of psychotherapy and antidepressant medication, or clear documentation why not.
The psychiatrist delivered education about the medication, including signs of new or worsening suicidality, and the high risk times for this side effect.
If provider was not an M.D., there was documentation of a referral for a medical/psychiatric evaluation if any of the following are present: psychotic features, complicating medical/psychiatric conditions, severity level of moderate or above.
ADHD
Diagnosis was determined based on input/rating scales from family members/caregivers, teachers, and other adults in the member's life.
Record indicated that the medical evaluation was reviewed to rule out medical causes for the signs and symptoms.
Psychoeducation was delivered to all members with ADHD and in the case of minors, to the parents/caregivers.
The treatment plan and rationale as well as available treatments, including medications and their benefits, risks, side effects, were discussed with the member and the parent/caregiver in the case of minors.

Record indicated the use of family interventions that coach parents on contingency management methods.
Record indicated a comprehensive assessment for comorbid psychiatric disorders was conducted.
Substance Use
Education was delivered about substance-use disorders.
A plan for maintaining sobriety, including strategies to address triggers was developed, and the role of substance use in increasing suicide risk was discussed.
The treatment plan included a referral to self-help groups such as AA, Al-Anon, and NA.
Evaluation included the consideration of appropriate psychopharmacotherapy.
For MD providers, evidence that abstinence-aiding medications were considered.
If provider was not a MD, there was evidence that a referral for abstinence-aiding medication or a diagnostic consultation was considered.
Schizophrenia
Assessment for other psychiatric disorders and medical conditions that may cause symptoms and/or complicate treatment was completed.
Education was delivered regarding schizophrenia and its treatment to the member and the family.
If significant risk was found, the provider implemented a plan to manage the risk, including a plan for diminishing access to weapons/lethal means.
If provider was a not an MD, documentation of a referral for a psychiatric evaluation was included in the record

If a psychiatric referral was made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan.
If provider was an MD, and if there was several unsuccessful medication trials and/or severe suicidality, then the member was considered for ECT and/or Clozapine.
Generalized Anxiety Disorder-Adult
Diagnosis for GAD based on DSM-5 criteria
Member received education from physician about GAD, options for treatment and general prognosis
CBT based psychotherapy and/or psychopharmacotherapy considered as first line treatment.
Ongoing monitoring of symptoms that are assessed for severity
Generalized Anxiety Disorder-Children
Assessment for and/or diagnosis of GAD based on DSM-5 criteria.
Member and/or guardian received age/developmentally appropriate education from provider about GAD, options for treatment and general prognosis.
CBT based psychotherapy for child and guardian (and stress management) as well as psycho-pharmacotherapy considered as first line treatments. Children are closely monitored if psycho-pharmacotherapy is used.
Treatment plan involves child and guardian. There is documentation of ongoing monitoring and assessment for increased/decreased of symptoms.
Bipolar Disorder
Diagnosis is documented by type (acute manic, hypomania, mixed, or acute depressive episode)
Complete psychological assessment documented First-line treatment: psychotherapy using trauma-focused therapy or stress management and/or pharmacotherapy
Psychoeducation, psychotherapy, and family intervention provided as indicated.

Evidence of monitoring medication and managing adverse effects
Suicide Risk
High to intermediate level of acute risk for suicide and Risk Assessment documented
Psychosocial evaluation completed
Assessment of lethal means and limited access to lethal means if needed.
Assessment for indications for inpatient admission
Safety plan development if risk is not imminent including social support
Continued monitoring of patient status and reassessment of risk in follow-up contacts
Oppositional Defiant Disorder
Diagnosis is based on DSM-5 criteria.
There is evidence of a comprehensive assessment for comorbid diagnoses being conducted.
There is evidence of a biopsychosocial assessment being utilized to develop an individualized treatment plan.
There is evidence of education being delivered about ODD, options for tx, and general prognosis.
For individuals 18 years of age and younger, there is evidence of legal guardian/care-taker being involved in treatment interventions.
Post-Traumatic Stress Disorder
Diagnosis is based on DSM-5 criteria.
There is evidence of a comprehensive assessment for comorbid diagnoses being conducted.

There is evidence of education being delivered about PTSD, its treatment, and benefits/risks associated with trauma related treatment interventions.
If provider is Prescriber, there is evidence that first line recommended treatment of SSRIs were considered.
If provider is not Prescriber, there is evidence of referral to a Prescriber to evaluate for appropriateness of psychopharmacotherapy.
If provider made referral to and/or member has established Prescriber, there is evidence of coordination of care with Prescriber.

TGH: INITIAL EVALUATION
There is evidence of a standardized assessment tool such as the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment.
The assessment protocol must differentiate across life domains.
The assessment protocol must differentiate between risk factors.
The assessment protocol must differentiate between protective factors.
The assessment protocol must track progress over time.
The supervising practitioner must complete an initial diagnostic assessment at admission or within 72 of admission and prior to service delivery.
The supervising practitioner must complete an initial diagnostic assessment prior to service delivery.
Must provide face to face assessment of the member at least every 28 days or more often as necessary.
Assessments shall be completed with the involvement of the child or adolescent to the extent possible.
Assessments shall be completed with the involvement of the family and/or support system , to the extent possible.

The assessment protocol documents less intensive levels of treatment have been determined to be unsafe, unsuccessful or unavailable.
TGH: TREATMENT PLAN
There is evidence of a treatment planning tool such as the CALOCUS/CANS being utilized for treatment planning.
Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the member. Pg 33
Be based on both clinical and functional assessments
Assist with the development of skills for daily living.
Focus on reducing the behavior and/or symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation.
Be implemented with oversight from a licensed mental health professional (LMHP)
Transition the child or adolescent from TGH to home- or community-based living, with outpatient treatment

Care coordination is provided to arrange for access of educational services.
Care coordination is provided to plan access to a range of educational services.
Care coordination is provided to arrange for access of therapeutic services.
Care coordination is provided to plan access to a range of therapeutic services.
Be identified in partnership with the child or adolescent, to the extent possible.
Be identified in partnership with the family and/or support system, to the extent possible.
The treatment plan must include behaviorally measurable discharge goals.
TGH: MEDICATION MANAGEMENT
Psychotropic medications should be used with specific target symptoms identification.
Psychotropic medications should be used with medical monitoring.
Psychotropic medications should be used with 24-hour medical availability when appropriate and relevant.
TGH: DISCHARGE PLANNING

Discharge planning within the first week of admission with clear action steps.
Discharge planning with target dates outlined in the treatment plan.
ADDITIONAL TGH
Recreational activities are provided for all enrolled members.
Members attend community-based school, work and/or training.
The psychologist or psychiatrist must see the member at least once.
The psychologist or psychiatrist must prescribe the type of care provided.
The individualized, strengths-based services and supports are based on functional assessments.
The individualized, strengths-based services and supports support success in community settings, including home and school.
The TGH is required to coordinate with the child's or adolescent's community resources, including schools with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.

PRTF Scoring Grid

PRTF: INITIAL EVALUATION
A diagnostic evaluation must be conducted within the first 24 hours of admission in consultation with the youth. Pg43
A diagnostic evaluation must be conducted within the first 24 hours of admission in consultation with the parents/legal guardian.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the medical aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the psychological aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the social aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the behavioral aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the developmental aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that reflects the need for inpatient psychiatric care.
PRTF: TREATMENT PLAN
The plan must be developed no later than 72 hours after admission

The plan must be implemented no later than 72 hours after admission
The plan must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to determine that services being provided are or were required on an inpatient basis
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of therapies designed to meet the objectives.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of activities designed to meet the objectives.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of experiences designed to meet the objectives.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, post-discharge plans.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, coordination of inpatient services, with partial discharge plans.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's family upon discharge.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's school upon discharge.

The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's community upon discharge.
ADDITIONAL PRTF
Must have access to education services, including supports to attend public school if possible, or in-house educational components, or vocational components if serving adolescents.
Member’s health is maintained (e.g. dental hygiene for a child expected to reside in the facility for 12 months). Pg 51

ASAM Level 1

SUD CORE REQUIREMENTS: INITIAL EVALUATION
Triage screening to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain significant medical history.
The comprehensive bio-psychosocial evaluation shall contain current health status.

The comprehensive bio-psychosocial evaluation shall contain family history.
The comprehensive bio-psychosocial evaluation shall contain social history.
The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation shall contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.
The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.

The comprehensive bio-psychosocial evaluation shall contain current legal status.
The comprehensive bio-psychosocial evaluation shall contain past emotional state.
The comprehensive bio-psychosocial evaluation shall contain present emotional state.
The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain strengths.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.
The comprehensive bio-psychosocial evaluation shall contain needs.
The evaluation must be reviewed and signed by an LMHP.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.

An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.
SUD CORE REQUIREMENTS: TREATMENT PLAN
Treatment plans are based on evaluations.
Treatment plans include person centered goals.
Treatment plans include person centered objectives.
Treatment plan shall include other medical/remedial services intended to reduce the identified condition.
The treatment plan should include anticipated outcomes of the individual.
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan specifies the amount.

The provider shall ensure that its clinical supervisor, the responsible LMHP or physician shall attend and participate in treatment planning as evidenced by their signature on relevant documentation. *exception of opioid treatment programs
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).
The re-evaluation must involve the family and/or legal representative.
Re-evaluations must determine if services have contributed to meeting the stated goals.
If a new treatment plan is developed due to no measureable reduction of disability or restoration of functional level, it includes a different rehabilitation strategy.
If a new treatment plan is developed due to no measureable reduction of disability or restoration of functional level, it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
ASAM LEVEL 1 REQUIREMENTS: The treatment plan is reviewed/updated in collaboration with the member, as needed, at a minimum of every 90 days or more frequently if indicated by the member's needs.
SUD CORE REQUIREMENTS: CONTINUITY & COORDINATION OF CARE

Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.
SUD CORE REQUIREMENTS: MEDICATION MANAGEMENT
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.
SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
SUD CORE REQUIREMENTS: DISCHARGE PLANNING

Documentation of discharge/transfer planning at admission.
Documentation of referrals made as needed, Remove: if applicable.
SUD ADDITIONAL CORE REQUIREMENTS
Treatment services at all levels of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication with the family and/or legal guardian.
Documentation of services provided to children and youth must include coordination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.

ASAM LEVEL 1 REQUIREMENTS: Evidence of early intervention for those who have been identified as individuals suffering from addictive disorders.
ASAM LEVEL 1 REQUIREMENTS: Evidence of referrals for education, activities or support services designed to prevent progression of disease if indicated.
Admission Guidelines
ASAM LEVEL 1 REQUIREMENTS: Documentation of transfer between facilities and/or treatment levels
ASAM LEVEL 1 REQUIREMENTS: Documentation of relapse assessment
ASAM LEVEL 1 REQUIREMENTS: Documentation of continuing care for those who require a step-down, following a more intensive level of care and require minimal support to avoid relapse;

ASAM Level 2.1

SUD CORE REQUIREMENTS: INITIAL EVALUATION
Triage screening to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain current health status.
The comprehensive bio-psychosocial evaluation shall contain social history.

The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation shall contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.
The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain current legal status.
The comprehensive bio-psychosocial evaluation shall contain past emotional state.

The comprehensive bio-psychosocial evaluation shall contain present emotional state.
The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.
SUD CORE REQUIREMENTS: TREATMENT PLAN
Treatment plans are based on evaluations.
Treatment plans include person centered goals.

Treatment plans include person centered objectives.
Treatment plan shall include other medical/remedial services intended to reduce the identified condition.
The treatment plan should include anticipated outcomes of the individual.
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan specifies the amount.
The provider shall ensure that its clinical supervisor, the responsible LMHP or physician shall attend and participate in treatment planning as evidenced by their signature on relevant documentation. ***exception of opioid treatment programs**
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).
The re-evaluation must involve the family and/or responsible party.
Re-evaluations must determine if services have contributed to meeting the stated goals.
If a new treatment plan is developed it includes a different rehabilitation strategy.

If a new treatment plan is developed it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
ASAM LEVEL 2.1 REQUIREMENTS: The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every 30 days or more frequently if indicated by the member's needs.
SUD CORE REQUIREMENTS: PROGRESS NOTES
ASAM LEVEL 2.1 REQUIREMENTS: Progress notes include documentation of evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and/or multidimensional family therapy.
SUD CORE REQUIREMENTS: CONTINUITY & COORDINATION OF CARE
Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.
SUD CORE REQUIREMENTS: MEDICATION MANAGEMENT
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.

SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.
SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
SUD CORE REQUIREMENTS: DISCHARGE PLANNING
Documentation of discharge/transfer planning at admission.
Documentation of referrals made as needed, Remove: if applicable.
SUD ADDITIONAL CORE REQUIREMENTS
Treatment services at all levels of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.

Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication with the family and/or legal guardian.
Documentation of services provided to children and youth must include coordination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in **treatment planning** activities as evidenced by their signature on relevant documentation.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such **activities as recreation, art/music or vocational education** as evidenced by their signature on relevant documentation.

ASAM Level 2-WM

SUD CORE REQUIREMENTS: INITIAL EVALUATION
Triage screening to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment.

The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain significant medical history.
The comprehensive bio-psychosocial evaluation shall contain current health status.
The comprehensive bio-psychosocial evaluation shall contain family history.
The comprehensive bio-psychosocial evaluation shall contain social history.
The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation shall contain relationships with family and/or significant others.

The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.
The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain current legal status.
The comprehensive bio-psychosocial evaluation shall contain past emotional state.
The comprehensive bio-psychosocial evaluation shall contain present emotional state.

The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain strengths.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.
The comprehensive bio-psychosocial evaluation shall contain needs.
The evaluation must be reviewed and signed by an LMHP.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.

Evaluations shall include the consideration of appropriate psychopharmacotherapy.
SUD CORE REQUIREMENTS: TREATMENT PLAN
Treatment plans are based on evaluations.
Treatment plans include person centered goals.
Treatment plans include person centered objectives.
Treatment plan shall include other medical/remedial services intended to reduce the identified condition.
The treatment plan should include anticipated outcomes of the individual.
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan specifies the amount.

The provider shall ensure that its clinical supervisor, the responsible LMHP or physician shall attend and participate in treatment planning as evidenced by their signature on relevant documentation. ***exception of opioid treatment programs**
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).
The re-evaluation must involve the family and/or legal representative.
Re-evaluations must determine if services have contributed to meeting the stated goals.
If a new treatment plan is developed it includes a different rehabilitation strategy.
If a new treatment plan is developed it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
ASAM LEVEL 2-WM REQUIREMENTS: The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every 30 days or more frequently if indicated by the member's needs.
ASAM LEVEL 2-WM: The treatment plan is reviewed and signed by the individual within 24 hours of admission or documentation of why not.
SUD CORE REQUIREMENTS: PROGRESS NOTES

Progress notes document the implementation of the stabilization/treatment plan.
Progress notes document the individual's response to and/or participation in scheduled activities.
Progress notes document the individual's physical condition.
Progress notes document the individual's vital signs.
Progress notes document The individual's mood.
Progress notes document the individual's behavior.
Progress notes document statements about the individual's condition.
Progress notes document statements about the individual's needs.
Progress notes document Information about the individual's progress or lack of progress in relation to stabilization/treatment goals.
SUD CORE REQUIREMENTS: CONTINUITY & COORDINATION OF CARE
Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.

Evidence that ambulatory withdrawal management (ASAM L2-WM) is provided in conjunction with ASAM L2.1 IOP services.
SUD CORE REQUIREMENTS: MEDICATION MANAGEMENT
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.
SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
SUD CORE REQUIREMENTS: DISCHARGE PLANNING

Documentation of discharge/transfer planning at admission.
Documentation of referrals made as needed, Remove: if applicable.
SUD ADDITIONAL CORE REQUIREMENTS
Treatment services at all levels of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication with the family and/or legal guardian.
Documentation of services provided to children and youth must include coordination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.

ASAM LEVEL 2-WM: Evidence of admission drug screen.
ASAM LEVEL 2-WM: Evidence of additional urine drug screens as indicated by the treatment plan.
ASAM LEVEL 2-WM: Evidence of physicians' orders for medical management.
ASAM LEVEL 2-WM: Evidence of physicians' orders for psychiatric management.

ASAM Level 3.1 Scoring Grid
SUD CORE REQUIREMENTS: INITIAL EVALUATION
Triage screening to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain significant medical history.
The comprehensive bio-psychosocial evaluation shall contain current health status.

The comprehensive bio-psychosocial evaluation shall contain family history.
The comprehensive bio-psychosocial evaluation shall contain social history.
The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation shall contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.
The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain current legal status.

The comprehensive bio-psychosocial evaluation shall contain past emotional state.
The comprehensive bio-psychosocial evaluation shall contain present emotional state.
The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain strengths.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.
The comprehensive bio-psychosocial evaluation shall contain needs.
The evaluation must be reviewed and signed by an LMHP.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.

SUD CORE REQUIREMENTS: TREATMENT PLAN
Treatment plans are based on evaluations.
Treatment plans include person centered goals.
Treatment plans include person centered objectives.
Treatment plan shall include other medical/remedial services intended to reduce the identified condition.
The treatment plan should include anticipated outcomes of the individual.
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan specifies the amount.
The provider shall ensure that its clinical supervisor, the responsible LMHP or physician shall attend and participate in treatment planning as evidenced by their signature on relevant documentation. ***exception of opioid treatment programs**
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).
The re-evaluation must involve the family and/or responsible party.
Re-evaluations must determine if services have contributed to meeting the stated goals.
The treatment plan shall be updated and revised if there is no measureable reduction of disability or restoration of functional level.

If a new treatment plan is developed it includes a different rehabilitation strategy.
If a new treatment plan is developed it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
LEVEL 3.1 ADULT/ADOLESCENT: Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.
LEVEL 3.1 ADULT/ADOLESCENT: Treatment plan updates every 90 days or as indicated by member needs.
SUD CORE REQUIREMENTS: CONTINUITY & COORDINATION OF CARE
Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.
SUD CORE REQUIREMENTS: MEDICATION MANAGEMENT
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis. ***OUD or AUD are appropriate for MAT**
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.

SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.
SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
SUD CORE REQUIREMENTS: DISCHARGE PLANNING
Documentation of discharge/transfer planning at admission.
Documentation of referrals made as needed.
SUD ADDITIONAL CORE REQUIREMENTS
Treatment services at all levels of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication with the family and/or legal guardian.
Documentation of services provided to children and youth must include coordination with the family and/or legal guardian.

The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.
ADMISSIONS
Documentation of minimal/stable withdrawal risk
If member is experiencing biomedical conditions and complications, documentation member is receiving medical monitoring
If emotional, behavioral or cognitive conditions are present, they do not prohibit member from participating in treatment.
Documentation member is open to recovery
Documentation member understand the risk of relapse, but lacks relapse prevention skills or requires a structured environment

ASAM Level 3.2-WM Scoring Grid

SUD CORE REQUIREMENTS: INITIAL EVALUATION
Triage screening to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain significant medical history.
The comprehensive bio-psychosocial evaluation shall contain current health status.

The comprehensive bio-psychosocial evaluation shall contain family history.
The comprehensive bio-psychosocial evaluation shall contain social history.
The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation shall contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.
The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain current legal status.

The comprehensive bio-psychosocial evaluation shall contain past emotional state.
The comprehensive bio-psychosocial evaluation shall contain present emotional state.
The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain strengths.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.
The comprehensive bio-psychosocial evaluation shall contain needs.
The evaluation must be reviewed and signed by an LMHP.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.

ASAM LEVEL 3.2-WM ADULT/ADOLESCENTREQUIREMENTS: Medical clearance and screening - Medical screening is performed upon arrival by staff with current CPR and first aid training, with telephone access to RN physician for instructions for the care of the individual.
ASAM LEVEL 3.2-WM ADULT/ADOLESCENTREQUIREMENTS: Individuals who require medication management must be transferred to medically monitored or medical withdrawal management program until stabilized.
SUD CORE REQUIREMENTS: TREATMENT PLAN
Treatment plans are based on evaluations.
Treatment plans include person centered goals.
Treatment plans include person centered objectives.
Treatment plan shall include other medical/remedial services intended to reduce the identified condition.
The treatment plan should include anticipated outcomes of the individual.
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan specifies the amount.
The provider shall ensure that its clinical supervisor, the responsible LMHP or physician shall attend and participate in treatment planning as evidenced by their signature on relevant documentation. ***exception of opioid treatment programs**
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).

The re-evaluation must involve the family and/or responsible party.
Re-evaluations must determine if services have contributed to meeting the stated goals.
The treatment plan shall be updated and revised if there is no measureable reduction of disability or restoration of functional level.
If a new treatment plan is developed it includes a different rehabilitation strategy.
If a new treatment plan is developed it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
ASAM LEVEL 3.2-WM ADULT/ADOLESCENTREQUIREMENTS: The treatment plan is developed in collaboration with the member within 24 hours or documentation of why not.
ASAM LEVEL 3.2-WM ADULT/ADOLESCENTREQUIREMENTS: The treatment plan is reviewed and signed by the qualified professional within 24 hours of admission.
ASAM LEVEL 3.2-WM ADULT/ADOLESCENTREQUIREMENTS: The treatment plan is reviewed and signed by the member within 24 hours of admission.
ASAM LEVEL 3.2-WM ADULT/ADOLESCENTREQUIREMENTS: The signed treatment plan must be filed in the member's record within 24 hours of admission.
SUD CORE REQUIREMENTS: PROGRESS NOTES
Progress notes document the implementation of the stabilization/treatment plan.

Progress notes document the individual's response to and/or participation in scheduled activities.
Progress notes document the individual's physical condition.
Progress notes document the individual's vital signs.
Progress notes document The individual's mood.
Progress notes document the individual's behavior.
Progress notes document statements about the individual's condition.
Progress notes document statements about the individual's needs.
Progress notes document Information about the individual's progress or lack of progress in relation to stabilization/treatment goals.
Daily assessment of progress through withdrawal management shall be documented in a manner that is person-centered.
Daily assessment of progress through withdrawal management shall be documented in a manner that is individualized.
SUD CORE REQUIREMENTS: CONTINUITY & COORDINATION OF CARE
Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.
SUD CORE REQUIREMENTS: MEDICATION MANAGEMENT

There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.
SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
SUD CORE REQUIREMENTS: DISCHARGE PLANNING
Documentation of discharge/transfer planning at admission.
Documentation of referrals made as needed, Remove: if applicable.
SUD ADDITIONAL CORE REQUIREMENTS
Treatment services at all levels of care shall offer a family component.

Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication with the family and/or legal guardian.
Documentation of services provided to children and youth must include coordination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.
ASAM LEVEL 3.2-WM ADULT/ADOLESCENT REQUIREMENTS: Evidence of physicians' orders for medical management.
ASAM LEVEL 3.2-WM ADULT/ADOLESCENT REQUIREMENTS: Evidence of physicians' orders for psychiatric management.
ASAM LEVEL 3.2-WM ADULT/ADOLESCENT REQUIREMENTS: Evidence of toxicology and drug screening – Toxicology and drug screenings are medically monitored.
ASAM Level 3.2-WM Adolescent TGH ASAM Requirement (In addition to the staffing required by TGHs): There is a physician on duty as needed for management/review/approval of psychiatric and/or medical needs of the client through course of stay as evidence by signature and/or relevant documentation.
ADMISSIONS

Documentation the member is experiencing signs and symptoms of withdrawal, or there is evidence that a withdrawal syndrome is imminent (based on history of substance use, age, gender, or previous withdrawal).
Documentation the member is assessed as not requiring medications, but requires this level of service to complete detoxification
Documentation that the member has biomedical conditions and complications are none or mild.
If emotional, behavioral or cognitive conditions are present, there is documentation that they do not prohibit member from participating in treatment.
Documentation the member has little awareness and needs intervention to engage and stay in treatment, or there is high severity in this dimension.
Documentation of member's relapse, continued use or continued problem potential.
Documentation the member's recovery environment is not supportive of detoxification and entry into treatment.
Documentation the member does not have sufficient coping skills to safely deal with the problems in their recovery environment or the patient recently has not demonstrated an inability to complete detoxification at a less intensive level of service, as by continued substance use.

ASAM Level 3.3 Scoring Grid

SUD CORE REQUIREMENTS: INITIAL EVALUATION
Triage screening to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain significant medical history.

The comprehensive bio-psychosocial evaluation shall contain current health status.
The comprehensive bio-psychosocial evaluation shall contain family history.
The comprehensive bio-psychosocial evaluation shall contain social history.
The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation shall contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.
The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.

The comprehensive bio-psychosocial evaluation shall contain current legal status.
The comprehensive bio-psychosocial evaluation shall contain past emotional state.
The comprehensive bio-psychosocial evaluation shall contain present emotional state.
The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain strengths.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.
The comprehensive bio-psychosocial evaluation shall contain needs.
The evaluation must be reviewed and signed by an LMHP.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.

SUD CORE REQUIREMENTS: TREATMENT PLAN
Treatment plans are based on evaluations.
Treatment plans include person centered goals.
Treatment plans include person centered objectives.
Treatment plan shall include other medical/remedial services intended to reduce the identified condition.
The treatment plan should include anticipated outcomes of the individual.
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan specifies the amount.
The provider shall ensure that its clinical supervisor, the responsible LMHP or physician shall attend and participate in treatment planning as evidenced by their signature on relevant documentation. ***exception of opioid treatment programs**
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).
The re-evaluation must involve the family and/or responsible party.
Re-evaluations must determine if services have contributed to meeting the stated goals.
The treatment plan shall be updated and revised if there is no measureable reduction of disability or restoration of functional level.
If a new treatment plan is developed it includes a different rehabilitation strategy.

If a new treatment plan is developed it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
ASAM LEVEL 3.3 REQUIREMENTS: An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals shall be developed.
ASAM LEVEL 3.3 REQUIREMENTS: An individualized, interdisciplinary treatment plan shall be developed in collaboration with the member.
ASAM LEVEL 3.3 REQUIREMENTS: Treatment plan updates every 90 days or as indicated by member needs.
SUD CORE REQUIREMENTS: CONTINUITY & COORDINATION OF CARE
Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.
SUD CORE REQUIREMENTS: MEDICATION MANAGEMENT
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.

SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
SUD CORE REQUIREMENTS: DISCHARGE PLANNING
Documentation of discharge/transfer planning at admission.
Documentation of referrals made as needed, Remove: if applicable.
SUD ADDITIONAL CORE REQUIREMENTS
Treatment services at all levels of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication with the family and/or legal guardian.
Documentation of services provided to children and youth must include coordination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.

The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering weekly parenting classes in which attendance is required.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of addressing the specialized needs of the parent.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering education for its parent members that further addresses effects of chemical dependency on a women's health and/or pregnancy.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering rehabilitation services for its parent members that further addresses effects of chemical dependency on a women's health and/or pregnancy.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering education for its parent members that further address parenting skills.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering counseling for its parent members that further address parenting skills.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering rehabilitation services for its parent members that further address parenting skills.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering education for its parent members that further address health and/or nutrition.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering counseling for its parent members that further address health and/or nutrition.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of offering rehabilitation services for its parent members that further address health and/or nutrition.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of regularly assessing parent-child interactions.

ASAM LEVEL 3.3 REQUIREMENTS: Evidence of addressing any identified needs in treatment.
ASAM LEVEL 3.3 REQUIREMENTS: Evidence of providing access to family planning services.
ASAM LEVEL 3.3 REQUIREMENTS: The provider shall address the specialized needs and/or care for the dependent children.
ASAM LEVEL 3.3 REQUIREMENTS: The provider shall address the therapeutic needs and/or care for the dependent children.
ASAM LEVEL 3.3 REQUIREMENTS: The provider shall develop an individualized plan of care to address those needs to include target dates.
ASAM LEVEL 3.3 REQUIREMENTS: The provider shall provide age-appropriate education for children.
ASAM LEVEL 3.3 REQUIREMENTS: The provider shall provide age-appropriate counseling for children.
ASAM LEVEL 3.3 REQUIREMENTS: The provider shall provide age-appropriate rehabilitation services for children.
ADMISSIONS
Documentation the member has no, or minimal risk of withdrawal
Documentation the member has biomedical conditions and complications that are none or stable.
If biomedical conditions and complications are present, documentation member is receiving medical monitoring.

If emotional, behavioral or cognitive conditions are present, there is documentation that they do not prohibit member from participating in treatment.
Documentation member has little awareness of the need for continuing care or the existence of his/her substance use or mental health problem and need for treatment and thus has limited readiness to change.
Documentation of member's relapse, continued use or continued problem potential.
Documentation member is informed that environment is dangerous, but recovery is achievable within a 24hr structure

ASAM Level 3.5 Scoring Grid

SUD CORE REQUIREMENTS: INITIAL EVALUATION
Triage screening to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain significant medical history.

The comprehensive bio-psychosocial evaluation shall contain current health status.
The comprehensive bio-psychosocial evaluation shall contain family history.
The comprehensive bio-psychosocial evaluation shall contain social history.
The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation shall contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.
The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.

The comprehensive bio-psychosocial evaluation shall contain current legal status.
The comprehensive bio-psychosocial evaluation shall contain past emotional state.
The comprehensive bio-psychosocial evaluation shall contain present emotional state.
The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain strengths.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.
The comprehensive bio-psychosocial evaluation shall contain needs.
The evaluation must be reviewed and signed by an LMHP.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.
Evaluations shall include the consideration of appropriate psychopharmacotherapy.

Evaluations shall include the consideration of appropriate psychopharmacotherapy.
SUD CORE REQUIREMENTS: TREATMENT PLAN
Treatment plans are based on evaluations.
Treatment plans include person centered goals.
Treatment plans include person centered objectives.
Treatment plan shall include other medical/remedial services intended to reduce the identified condition.
The treatment plan should include anticipated outcomes of the individual.
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan specifies the amount.
The provider shall ensure that its clinical supervisor, the responsible LMHP or physician shall attend and participate in treatment planning as evidenced by their signature on relevant documentation. ***exception of opioid treatment programs**
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).
The re-evaluation must involve the family and/or responsible party.

Re-evaluations must determine if services have contributed to meeting the stated goals.
The treatment plan shall be updated and revised if there is no measureable reduction of disability or restoration of functional level.
If a new treatment plan is developed it includes a different rehabilitation strategy.
If a new treatment plan is developed it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
LEVEL 3.5 ADULT/ADOLESCENT REQUIREMENTS: An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals shall be developed.
LEVEL 3.5 ADULT/ADOLESCENT REQUIREMENTS: An individualized, interdisciplinary treatment plan shall be developed in collaboration with the member.
LEVEL 3.5 ADULT/ADOLESCENT REQUIREMENTS: Treatment plan updates every 30 days or as indicated by member needs.
LEVEL 3.5 ADULT/ADOLESCENT REQUIREMENTS: There is evidence in the record of an in-house education/vocational component if serving adolescents.
SUD CORE REQUIREMENTS: CONTINUITY & COORDINATION OF CARE
Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.

SUD CORE REQUIREMENTS: MEDICATION MANAGEMENT
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.
SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
SUD CORE REQUIREMENTS: DISCHARGE PLANNING
Documentation of discharge/transfer planning at admission.
Documentation of referrals made as needed, Remove: if applicable.

SUD ADDITIONAL CORE REQUIREMENTS
Treatment services at all levels of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication with the family and/or legal guardian.
Documentation of services provided to children and youth must include coordination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.
ADMISSIONS
Documentation the member has no, or minimal risk of withdrawal.
Documentation the member has biomedical conditions and complications that are none or stable.
If biomedical conditions and complications are present, documentation member is receiving medical monitoring

If emotional, behavioral or cognitive conditions are present, there is documentation that they do not prohibit member from participating in treatment.
Documentation that motivational interventions have not succeeded at a less intensive level of care
Documentation of member's relapse, continued use or continued problem potential.
Documentation that living environment has high risk of neglect or abuse
Documentation that member lacks skills to cope outside of highly structured 24hr setting

OTP REQUIREMENTS
Screening
A screening is conducted to determine eligibility for admission.
A screening is conducted to determine eligibility for referral.
A screening is conducted to determine appropriateness for admission.
A screening is conducted to determine appropriateness for referral.

A complete physical examination by the OTP's physician must be conducted before admission to the OTP.
Members who meet clinical criteria must be at least 18 years old, unless the member has consent from a parent or legal guardian, if applicable, and the State Opioid Treatment Authority.
Physical Examination
A drug screening test by the OTP's physician must be conducted before admission to the OTP.
A full medical exam, including results of serology and other tests, must be completed within 14 days of admission.

The physician shall ensure members have a Substance Use or Opioid Use Disorder.
An OUD must be present for at least one year before admission for treatment, or meet exception criteria, as set in federal regulations.
Alcohol and Drug Assessment and Referrals
ASAM OTP REQUIREMENT: comprehensive bio-psychosocial assessment must be completed within the first seven (7) days of admission, which substantiates treatment.
For new admissions, the American Society of Addiction Medicine (ASAM) 6 Dimensional risk evaluation must be included in the assessment.
The assessment must be reviewed by a licensed mental health professional (LMHP).
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.

The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain significant medical history.
The comprehensive bio-psychosocial evaluation shall contain current health status.

The comprehensive bio-psychosocial evaluation shall contain family history.
The comprehensive bio-psychosocial evaluation shall contain social history.
The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin (nuclear), family, and/or significant others.
The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.

The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain current legal status.
The comprehensive bio-psychosocial evaluation shall contain past emotional state.
The comprehensive bio-psychosocial evaluation shall contain present emotional state.

The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain strengths.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.
The comprehensive bio-psychosocial evaluation shall contain needs.
Assessments shall include the consideration of appropriate psychopharmacotherapy.
Medication Management
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis. **OUD or AUD are appropriate for MAT*

SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.
SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
Treatment Planning Process

The treatment plan must be developed within 7 days of admission by the treatment team.
The treatment plan must be based on the assessments.
The treatment plan must include person centered goals.
The treatment plan must include person centered objectives.
The treatment plan must Identify the services intended to reduce the identified condition.
The treatment plan must include anticipated outcomes of the individual.
The treatment plan must include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan must specify the amount of services.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
Treatment plan must specify a timeline for re-evaluation of that plan that is, at least, an annual redetermination.

The re-evaluation must involve the family and/or responsible party.
Re-evaluations must determine if services have contributed to meeting the stated goals.
The treatment plan shall be updated and revised if there is no measureable reduction of disability or restoration of functional level.
If a new treatment plan is developed it includes a different rehabilitation strategy.
If a new treatment plan is developed it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
Treatment Services
During the initial treatment phase the provider conducts orientation. ***Initial treatment phase lasts from three to seven days.**
During the initial treatment phase the provider conducts counseling.***Initial treatment phase lasts from three to seven days.**

During the initial treatment phase the provider develops the initial treatment plan for treatment of critical health or social issues. ***Initial treatment phase lasts from three to seven days.**
During early stabilization, the provider conducts weekly monitoring of the member's response to medication. ***Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.**
During early stabilization, the provider provides at least four individual counseling sessions. ***Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.**
During early stabilization, the provider revises the treatment plan within 30 days to include input by all disciplines. ***Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.**

During early stabilization, the provider revises the treatment plan within 30 days to include input by the member. ***Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.**
During early stabilization, the provider revises the treatment plan within 30 days to include input by significant others. ***Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.**
During early stabilization, the provider conducts random monthly drug screen tests. ***Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.**
During maintenance treatment, the provider performs random monthly drug screen tests until the member has negative drug screen tests for 90 consecutive days as well as random testing for alcohol when indicated. ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**

During maintenance treatment, after the member has obtained a negative drug screen for 90 consecutive days, monthly testing to members who are allowed six days of take home doses, as well as random testing for alcohol when indicated ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**
During maintenance treatment, After the member has obtained a negative drug screen for 90 consecutive days, random testing for alcohol when indicated ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**
During maintenance treatment, Continuous evaluation by the nurse of the member's use of treatment from the program. ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**
During maintenance treatment, The provider shall documented reviews of the treatment plan every 90 days in the first two years of treatment by the treatment team. ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**

During maintenance treatment, The provider shall documentation of response to treatment in a progress note at least every 30 days. ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**
During Medically supervised withdrawal from synthetic narcotic with continuing care, the provider shall decrease the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, as medically tolerated by member. ***Medically supervised withdrawal from synthetic narcotic occurs only when withdrawal is requested by the member.**
During Medically supervised withdrawal from synthetic narcotic with continuing care, the provider shall provide counseling of the type based on medical necessity. ***Medically supervised withdrawal from synthetic narcotic occurs only when withdrawal is requested by the member.**
During Medically supervised withdrawal from synthetic narcotic with continuing care, the provider shall conduct discharge planning as appropriate. ***Medically supervised withdrawal from synthetic narcotic occurs only when withdrawal is requested by the member.**

Evidence that those with take home medication privilege have absence of criminal activity during treatment
Evidence that those with take home medication privilege the member must have negative drug/alcohol screen for at least 30 days
Evidence that those with take home medication privilege the member must have regular clinic attendance
Evidence that those with take home medication privilege the member must have absence of serious behavioral problems during treatment
Evidence that those with take home medication privilege the member must have stability of home environment
Evidence that those with take home medication privilege the member must have stability of social relationships
Evidence that take-home medication can be safely stored (lock boxes provided by member).

Evidence that after the first 30 days and during the remainder of the first 90 days in treatment, one therapeutic dose per week was given to the member to self-administer at home. ***Treatment days 30 to 90 = one dose per week.**
Evidence that in the second 90 days, two therapeutic doses per week was given to the member to self-administer at home. Add for reviewer clarity: ***Treatment days 91 to 180 = two dose per week.**
Evidence that in the third 90 days of treatment, three therapeutic doses per week was given to the member to self-administer at home. ***Treatment days 181 to 270 = three dose per week.**
Evidence that in the final 90 days of treatment of the first year, four therapeutic doses per week was given to the member to self-administer at home. ***Treatment days 271 to 360 = four dose per week.**
Evidence the treatment team and medical director determined that the therapeutic privilege doses are appropriate that after one year in treatment, a six-day dose supply, consisting of take home doses and therapeutic doses may be allowed once a week. ***Treatment days 365 to 729 = six-day dose supply once per week.**

Evidence the treatment team and medical director determined that the therapeutic privilege doses are appropriate that after two years in treatment, a 13-day dose supply, consisting of take home doses and therapeutic doses may be allowed once every two weeks. ***Treatment day 730/2 year mark = 13/day dose supply once every two weeks.**
EXCEPTIONS - Take Home Meds
Evidence of a new determination made by the treatment team regarding take home privileges due to positive drug screens at any time for any drug other than prescribed.
Evidence of take home privileges being revoked due to the patient has a urine drug screen with any substances other than Methadone, Methadone Metabolites, or a medication that the patient does not have a valid prescription.
Care Coordination
Communication with the other health care providers as it relates to the member's OUD treatment in the member's treatment record.

Coordination with other health care systems shall occur, as needed, to achieve the treatment goals in the member's treatment record.
Member Record
Recording of dispensing in accordance with federal and state requirements
Documentation of physical status and use of additional prescription medication
Contact notes and/or progress notes (monthly, or more frequently, as indicated by needs of client) must include employment/vocational needs.
Contact notes and/or progress notes (monthly, or more frequently, as indicated by needs of client) must include legal status.
Contact notes and/or progress notes (monthly, or more frequently, as indicated by needs of client) must include social status.

Contact notes and/or progress notes (monthly, or more frequently, as indicated by needs of client) must include overall individual stability.
Documentation and confirmation of the factors to be considered in determining whether a take-home dose is appropriate, if necessary.
Documentation of approval of any exception to the standard schedule of take-home doses.
Documentation of physician’s justification for approval of any exception to the standard schedule of take-home doses.

Mobile Crisis Response (MCR) Specific Requirements
Preliminary Screening - Determination of Risk
There is evidence in the record that crisis services were not used as step down services
There is evidence in the record of a new or unforeseen documented crisis not otherwise addressed in the member's existing crisis plan.
There is evidence that the case records include preliminary Screening
There is evidence that the preliminary screening included the reason for presentation for services and/or the nature of the member's crisis.
There is evidence that the preliminary screening included the member's chief complaint
There is evidence that the preliminary screening included the grave disability
There is evidence that the preliminary screening included the risks of suicidality
There is evidence that the preliminary screening included the risk of self-harm
There is evidence that the preliminary screening included the risk of danger to others
There is evidence of a brief preliminary person-centered screening of risk
There is evidence that the brief preliminary person-centered screening of risk includes contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level
There is evidence of a brief preliminary mental status

There is evidence that the brief preliminary mental status includes the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level
There is evidence that a brief preliminary medical stability was conducted includes contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level
There is evidence that the further evaluation for other mental health services include contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or coordination in with other alternative behavioral health services at an appropriate level
When the member is referred from another crisis provider, there is evidence that a screening of risk is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a mental status is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a medical status is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a medical stability is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that there is a need for further evaluation or other mental health services and is built on the screening and assessments conducted by the previous crisis service providers.
Assessment
There is evidence that the case records include assessments, if applicable

If further evaluation is needed, there is evidence that the assessment was conducted by an licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service.
There is evidence, if a member is referred from another crisis provider and further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.
Documentation - Involvement of Family/ Natural Supports
There is evidence, if applicable, that substance use was addressed by providing engagement in care to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing support to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing education to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing consultation to the member, family, and collateral supports.
If further evaluation is needed, there is evidence that the assessment included contact with the member, family members or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level
There is evidence that member expressly refuses to include family or other collaterals sources
There is evidence that attempts to communicate with treating providers and family were documented
Interventions
There is evidence that the case records include notes on the interventions delivered after every encounter.
There is evidence that the case records include documentation of successful and/or failed encounters and/or attempts.
There is evidence that intervention strategies are built upon and/or updated by the MCR or BHCC service providers.
There is evidence that the interventions are driven by the member

There is evidence that the intervention includes resolution focused treatment designed to de-escalate the crisis.
There is evidence that the Interventions include resolution focused peer support designed to de-escalate the crisis
There is evidence that the interventions include resolution focused safety planning designed to de-escalate the crisis
There is evidence that the interventions include resolution focused service planning designed to de-escalate the crisis
There is evidence that the interventions include resolution focused care coordination designed to de-escalate the crisis
There is evidence that the strategies are developed for the member to use post current crisis.
There is evidence that the strategies are developed to mitigate risk of future incidents until the member engages in alternative services.
When the member is referred from another crisis provider to CBCS, there is evidence the intervention is driven by the member.
When a member is referred from another crisis provider to CBCS there is evidence the interventions are developed by the LMHP, psychiatrist or non-licensed staff in collaboration with the LMHP or psychiatrist building on and updating the strategies developed by the MCR or BHCC service providers.
There is evidence that the short-term goals were set to stabilization.
There is evidence that the short-term goals were set to ensure symptom reduction.
There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning
There is evidence that the interventions include using person centered approaches, such as resolution of the crisis resolution and problem solving of the crisis.
Coordination and Continuity of Care
There is evidence the member's record reflected relief of the identified crisis and/or referral to an alternate provider.
There is evidence the member's record reflected resolution of the identified crisis and/or referral to an alternate provider.
There is evidence the member's record reflected problem solving of the identified crisis and/or referral to an alternate provider.
There is evidence that all levels of crisis providers coordinated the transfer to alternate levels of care within 24 hours when warranted

There is evidence that providers coordinated the transfer to primary medical care when the member requires primary medical care with an existing provider
There is evidence that providers coordinated the transfer to Community based behavioral health provider when the member requires ongoing support at a lower level of care with the member's existing behavioral health provider
There is evidence that providers coordinated the transfer to another crisis provider when the member requires ongoing support, if applicable
There is evidence that providers coordinated the transfer to Inpatient treatment when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent, if applicable
There is evidence that providers coordinated the transfer to Residential substance use treatment when the member requires ongoing support and treatment outside of the home for a substance use disorder, if applicable
There is evidence that there was coordinated contact through a warm handoff with the member's MCO to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated.
There is evidence that any member records was provided to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral
Follow-Up Requirements
There is evidence in the record of a brief crisis plan/strategies were developed for the member to use post current crisis to mitigate the risk of future incidents until the member engages in alternative services, if appropriate.
There is evidence that follow up with the member and/or authorized member's caretaker/family were completed within 24 to 72 hours either telephonically or face to face post crisis to ensure stability for those not accessing higher levels of care or another crisis service.
There is evidence that follow up with the member and/or authorized member's caretaker/family were continued beyond 15 days post discharge from MCR and/or BHCC provider to ensure stability for those not accessing higher levels of care or another crisis service.

There is evidence that the member and/or authorized member's caretaker/family desired no further communication post crisis within the record, if applicable.
There is evidence the discharge summary included communications with family.
There is evidence the discharge summary included communications with treating providers.

Community Brief Crisis Support (CBCS) Specific Requirements
Preliminary Screening
There is evidence in the record that crisis services were not used as step down services
There is evidence in the record of a new or unforeseen documented crisis not otherwise addressed in the member's existing crisis plan.
There is evidence that the case records include preliminary Screening
There is evidence that the preliminary screening included the reason for presentation for services and/or the nature of the member's crisis.
There is evidence that the preliminary screening included the member's chief complaint
There is evidence that the preliminary screening included the grave disability
There is evidence that the preliminary screening included the risks of suicidality
There is evidence that the preliminary screening included the risk of self-harm
There is evidence that the preliminary screening included the risk of danger to others
There is evidence of a brief preliminary person-centered screening of risk
There is evidence that the brief preliminary person-centered screening of risk includes contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level
There is evidence of a brief preliminary mental status
There is evidence that the brief preliminary mental status includes the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level
There is evidence that a brief preliminary medical stability was conducted includes contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level

There is evidence that the further evaluation for other mental health services include contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or coordination in with other alternative behavioral health services at an appropriate level
When the member is referred from another crisis provider, there is evidence that a screening of risk is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a mental status is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a medical status is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a medical stability is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that there is a need for further evaluation or other mental health services and is built on the screening and assessments conducted by the previous crisis service providers.
Assessment
There is evidence that the case records include assessments, if applicable
If further evaluation is needed, there is evidence that the assessment was conducted by an licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service.
There is evidence, if a member is referred from another crisis provider and further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.
Documentation - Involvement of Family/Natural Supports
There is evidence, if applicable, that substance use was addressed by providing engagement in care to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing support to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing education to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing consultation to the member, family, and collateral supports.

If further evaluation is needed, there is evidence that the assessment included contact with the member, family members or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level
There is evidence that attempts to communicate with treating providers and family were documented
There is evidence that member expressly refuses to include family or other collaterals sources
Interventions
There is evidence that the case records include notes on the interventions delivered after every encounter.
There is evidence that the case records include documentation of successful and/or failed encounters and/or attempts.
There is evidence that intervention strategies are built upon and/or updated by the MCR or BHCC service providers.
There is evidence that the interventions are driven by the member
There is evidence that the intervention includes resolution focused treatment designed to de-escalate the crisis.
There is evidence that the Interventions include resolution focused peer support designed to de-escalate the crisis
There is evidence that the interventions include resolution focused safety planning designed to de-escalate the crisis
There is evidence that the interventions include resolution focused service planning designed to de-escalate the crisis
There is evidence that the interventions include resolution focused care coordination designed to de-escalate the crisis
There is evidence that the strategies are developed for the member to use post current crisis.
There is evidence that the strategies are developed to mitigate risk of future incidents until the member engages in alternative services.
When the member is referred from another crisis provider to CBCS, there is evidence the intervention is driven by the member.
When a member is referred from another crisis provider to CBCS there is evidence the interventions are developed by the LMHP, psychiatrist or non-licensed staff in collaboration with the LMHP or psychiatrist building on and updating the strategies developed by the MCR or BHCC service providers.
There is evidence that the short-term goals were set to stabilization.
There is evidence that the short-term goals were set to ensure symptom reduction.
There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning
There is evidence that the interventions include using person centered approaches, such as resolution of the crisis resolution and problem solving of the crisis.

Coordination and Continuity of Care
There is evidence the member's record reflected relief of the identified crisis and/or referral to an alternate provider.
There is evidence the member's record reflected resolution of the identified crisis and/or referral to an alternate provider.
There is evidence the member's record reflected problem solving of the identified crisis and/or referral to an alternate provider.
There is evidence that all levels of crisis providers coordinated the transfer to alternate levels of care within 24 hours when warranted
There is evidence that providers coordinated the transfer to primary medical care when the member requires primary medical care with an existing provider
There is evidence that providers coordinated the transfer to Community based behavioral health provider when the member requires ongoing support at a lower level of care with the member's existing behavioral health provider
There is evidence that providers coordinated the transfer to another crisis provider when the member requires ongoing support, if applicable
There is evidence that providers coordinated the transfer to Inpatient treatment when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent, if applicable
There is evidence that providers coordinated the transfer to Residential substance use treatment when the member requires ongoing support and treatment outside of the home for a substance use disorder, if applicable
There is evidence that there was coordinated contact through a warm handoff with the member's MCO to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated.
There is evidence that any member records was provided to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral
Follow-Up Requirements
There is evidence in the record of a brief crisis plan/strategies were developed for the member to use post current crisis to mitigate the risk of future incidents until the member engages in alternative services, if appropriate.
There is evidence that follow up with the member and/or authorized member's caretaker/family were completed either telephonically or face to face within 24 hours to 15 days following the initial contact with the CBCS provider once discharged from MCR and/or BHCC provider to ensure continued stability post crisis for those not accessing higher levels of care.

There is evidence that follow up with the member and/or authorized member's caretaker/family were continued beyond 15 days post discharge from MCR and/or BHCC provider to ensure stability for those not accessing higher levels of care or another crisis service.
There is evidence that the member and/or authorized member's caretaker/family desired no further communication post crisis within the record, if applicable.
There is evidence the discharge summary included communications with treating providers.
There is evidence the discharge summary included communications with family.

Behavioral Health Crisis Care (BHCC) Specific Requirements
Preliminary Screening - Determination of Risk
There is evidence that the case records include preliminary Screening
There is evidence that the preliminary screening included the reason for presentation for services and/or the nature of the member's crisis.
There is evidence that the preliminary screening included the member's chief complaint
There is evidence that the preliminary screening included the grave disability
There is evidence that the preliminary screening included the risks of suicidality
There is evidence that the preliminary screening included the risk of self-harm
There is evidence that the preliminary screening included the risk of danger to others
There is evidence of a brief preliminary person-centered screening of risk

There is evidence that the brief preliminary person-centered screening of risk includes contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level
There is evidence of a brief preliminary mental status
There is evidence that the brief preliminary mental status includes the member, family members or other collateral+A13:A20 sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level
There is evidence that a brief preliminary medical stability was conducted includes contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level
There is evidence that the further evaluation for other mental health services include contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or coordination in with other alternative behavioral health services at an appropriate level
When the member is referred from another crisis provider, there is evidence that a screening of risk is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a mental status is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a medical status is built on the screening and assessments conducted by the previous crisis service providers.
When the member is referred from another crisis provider, there is evidence that a medical stability is built on the screening and assessments conducted by the previous crisis service providers.

When the member is referred from another crisis provider, there is evidence that there is a need for further evaluation or other mental health services and is built on the screening and assessments conducted by the previous crisis service providers.
Medical Screen
There is evidence a registered nurse or licensed practical nurse practicing within the scope of his or her license performed a **medical screen to evaluate for medical stability**.
Assessment
There is evidence that the case records include assessments, if applicable
If further evaluation is needed, there is evidence that the assessment was conducted by an licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service.
If further evaluation is needed, there is evidence that the assessment included contact with the member, family members or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level
There is evidence, if a member is referred from another crisis provider and further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.
Documentation - Involvment of Family/Natural Supports
There is evidence, if applicable, that substance use was addressed by providing engagement in care to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing support to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing education to the member, family, and collateral supports.
There is evidence, if applicable, that substance use was addressed by providing consultation to the member, family, and collateral supports.
There is evidence that member expressly refuses to include family or other collaterals sources

There is evidence that attempts to communicate with treating providers and family were documented
There is evidence the discharge summary included communications with treating providers.
Interventions
There is evidence that the case records include notes on the interventions delivered after every encounter.
There is evidence that the case records include documentation of successful and/or failed encounters and/or attempts.
There is evidence that intervention strategies are built upon and/or updated by the MCR or BHCC service providers.
There is evidence that the interventions are driven by the member
There is evidence that the intervention includes resolution focused treatment designed to de-escalate the crisis.
There is evidence that the Interventions include resolution focused peer support designed to de-escalate the crisis
There is evidence that the interventions include resolution focused safety planning designed to de-escalate the crisis
There is evidence that the interventions include resolution focused service planning designed to de-escalate the crisis
There is evidence that the interventions include resolution focused care coordination designed to de-escalate the crisis
There is evidence that the strategies are developed for the member to use post current crisis.
There is evidence that the strategies are developed to mitigate risk of future incidents until the member engages in alternative services.
When the member is referred from another crisis provider to CBCS, there is evidence the intervention is driven by the member.
When a member is referred from another crisis provider to CBCS there is evidence the interventions are developed by the LMHP, psychiatrist or non-licensed staff in collaboration with the LMHP or psychiatrist building on and updating the strategies developed by the MCR or BHCC service providers.
There is evidence that the short-term goals were set to stabilization.
There is evidence that the short-term goals were set to ensure symptom reduction.
There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning

There is evidence that the interventions include using person centered approaches, such as resolution of the crisis resolution and problem solving of the crisis.
Coordination and Continuity of Care
There is evidence the member's record reflected relief of the identified crisis and/or referral to an alternate provider.
There is evidence the member's record reflected resolution of the identified crisis and/or referral to an alternate provider.
There is evidence the member's record reflected problem solving of the identified crisis and/or referral to an alternate provider.
There is evidence that all levels of crisis providers coordinated the transfer to alternate levels of care within 24 hours when warranted
There is evidence that providers coordinated the transfer to primary medical care when the member requires primary medical care with an existing provider
There is evidence that providers coordinated the transfer to Community based behavioral health provider when the member requires ongoing support at a lower level of care with the member's existing behavioral health provider
There is evidence that providers coordinated the transfer to another crisis provider when the member requires ongoing support, if applicable
There is evidence that providers coordinated the transfer to Inpatient treatment when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent, if applicable
There is evidence that providers coordinated the transfer to Residential substance use treatment when the member requires ongoing support and treatment outside of the home for a substance use disorder, if applicable
There is evidence that there was coordinated contact through a warm handoff with the member's MCO to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated.
There is evidence that any member records was provided to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral
There is evidence that services were appropriate for age of member

There is evidence that services were appropriate to the developmental abilities of member
There is evidence that services were appropriate to the education level of member
Follow-Up Requirements
There is evidence the discharge summary included communications with family.
There is evidence that a registered nurse or licensed practical nurse practicing within the scope of his or her license performs a medical screen to evaluate for the member's medical stability.
There is evidence that follow up with the member and/or authorized member's caretaker/family were completed within 24 to 72 hours either telephonically or face to face post crisis to ensure stability for those not accessing higher levels of care or another crisis service.
There is evidence that telephonic follow up with the member and/or authorized member's caretaker/family were continued beyond 72 hours post crisis to ensure stability for those not accessing higher levels of care or another crisis service when applicable.
There is evidence that the member and/or authorized member's caretaker/family desired no further

Crisis Stabilization (CS) Specific Requirements
Assessment
There is evidence that a referral is completed by Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), Community Brief Crisis Support providers or ACT Teams.
There is evidence that the member is in psychiatric crisis and in need of temporary twenty-four (24) hours a day, seven (7) days a week support to provide crisis relief, resolution, and intensive supportive resources.
There is evidence that the psychiatric diagnostic evaluation was completed.
There is evidence that if a psychiatric diagnostic evaluation was completed within thirty (30) days by previous provider, an update to capture the member's current status must be added to the previous evaluation.
There is evidence of **initial assessment** of CS needs, including crisis resolution and debriefing. (Youth CS section)
There is evidence of **ongoing assessment** of CS needs, including crisis resolution and debriefing. (Youth CS section)
There is evidence that the psychiatric diagnostic evaluation of risk included **mental status exam** conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service and practicing within the scope of his or her professional license.
Medical Screen
There is evidence that the preliminary assessment of youth's **medical stability** includes contact with the member, family members or other collateral sources(e.g., caregiver, school personnel) with pertinent information. (Youth CS section)
There is evidence a registered nurse or licensed practical nurse practicing within the scope of his or her license performed a **medical screen to evaluate for medical stability**.

There is evidence that the **psychiatric diagnosis evaluation of risk** included **medical stability** conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service and practicing within the scope of his or her professional license.
There is evidence that assessment is built upon what is learned by previous crisis response providers or the Assertive Community Treatment (ACT) provider.
Involvement of Family / Natural Supports
There is evidence of regular contact with family to prepare for the youth's return and his/her ongoing needs as part of the family. (Youth CS Section)
There is evidence that the assessment included contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of the evaluation and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level
There is evidence of follow up with individual and individual's caretaker and/or family members. (Youth CS Section)
There is documentation that the member expressly refuses to include family or other collaterals sources.
There is evidence that support was provided to the member, family and/or collateral supports.
There is evidence that education was provided to the member, family and/or collateral supports.
There is evidence that consultation was provided to the member, family and/or collateral supports.
Interventions
There is evidence of documentation that supports the need for short-term and intensive supportive resources for the youth and his/her family (Youth CS Section)
There is evidence that the interventions are driven by the member
There is evidence that interventions are developed by the LMHP, psychiatrist or non-licensed staff in collaboration with the LMHP or the psychiatrist.

The is evidence the interventions are built on the strategies developed by the mobile crisis response (MCR), Behavioral Health Crisis Care (BHCC), and/or community brief support service (CBCS) service providers.
There is evidence that the short-term goals are developed to ensure stabilization.
There is evidence that the short-term goals were set to ensure symptom reduction
There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning.
There is evidence that the interventions were developed with input from the member, family and/or other collateral sources.
There is evidence that the interventions are developed for member to use post crisis to mitigate risk of future incidents until member engages in alternative services, if appropriate.
There is evidence that the brief interventions include using person centered approaches.
There is evidence that substance use was recognized and addressed in an integrated fashion and assessing the need for engagement in care.
Care Coordination
There is evidence that providers coordinated the transfer to primary medical care within 24 hours.
There is evidence that providers coordinated the transfer to Community based behavioral health provider within 24 hours.
There is evidence that providers coordinated the transfer to Community Brief Crisis Support (CBCS) within 24 hours.
There is evidence that providers coordinated the transfer to Crisis Stabilization (CS) within 24 hours.

There is evidence that providers coordinated the transfer to Inpatient treatment within 24 hours.
There is evidence that providers coordinated the transfer to Residential substance use treatment within 24 hours.
There is evidence that readiness for discharge is evaluated daily.
There is evidence that a warm handoff with member's MCO to link member with no current BH provider and/or primary medical care provider to outpatient services as indicated
There is evidence of a warm handoff with member's existing or new BH provider.
There is evidence that member records was provided to the existing or new BH provider or to another crisis service to assist with continuing care upon referral.
There is evidence of consultation with physician and/or with other qualified providers to assist with youth's specific crisis. (Youth CS Section)
There is evidence that there was member involvement throughout the planning of services
There is evidence that there was member involvement throughout the delivery of services
Follow-Up
There is evidence that telephonic follow up to the member and/or authorized member's caretaker and/or family up to 72 hours to ensure continued stability post crisis for those not accessing CBCS or higher levels of care
There is evidence of additional calls/visits to member following the crisis unless the member indicates no further communication is desired as documented in the member's record.

Personal Care Agencies ASR
Personal Care Agencies ASR
There is evidence of services are provided on an individual level.
There is documentation that any changes in member's behavior that impact member's health and/or safety was reported to the **appropriate MCO**.
There is documentation that any changes in member's behavior that impact member's health and/or safety were reported to the **community case manager**, if applicable.
There is evidence of provider participation in team meetings, as requested by case manager, if applicable.
If the provider proposes involuntary transfer, discharge of a member, and/or if a provider closes in accordance with licensing standards, there is evidence that the provider gave written notice to the **member, a family member and/or the authorized representative**, if known, at least 30 calendar days prior to the transfer or the discharge
If the provider proposes involuntary transfer, discharge of a member, and/or if a provider closes in accordance with licensing standards, there is evidence that the provider gave written notice to the **case manager**, if applicable, at least 30 calendar days prior to the transfer or the discharge
If the provider proposes involuntary transfer, discharge of a member, and/or if aprovider closes in accordance with licensing standards, there is evidence that **written notice was made via certified mail**, return receipt requested
If the provider proposes involuntary transfer, discharge of a member, and/or if a provider closes in accordance with licensing standards, there is **evidence that written notice was in a language and manner that the member understands.**
If the provider proposes involuntary transfer, discharge of a member, and/or if aprovider closes in accordance with licensing standards, there is evidence **that a copy of the written discharge/transfer notice was placed in the member's record.**
There is evidence that the written discharge/transfer notice includes documentation **of the reason for transfer or discharge**.
There is evidence that the written discharge/transfer notice includes documentation of **the effective date of transfer or discharge**.
There is evidence that the written discharge/transfer notice includes documentation of **the explanation of a member's right** to personal and/or third parties' representation at all stages of the transfer or discharge.
There is evidence that the written discharge/transfer notice includes documentation of the **contact information for the Advocacy Center**.
There is evidence that the written discharge/transfer notice includes documentation of the names of provider personnel available to assit the member and family in **decision making**
There is evidence that the written discharge/transfer notice includes documentation of the names of provider personnel available to assit the member and family in **transfer arrangements**.
There is a copy of the written discharge/transfer notice is in the member's record that includes **time** for the discharge planning conference.
There is a copy of the written discharge/transfer notice is in the member's record that includes **place** for the discharge planning conference.

There is a copy of the written discharge/transfer notice is in the member's record that includes **date** for the discharge planning conference.
There is a copy of the written discharge/transfer notice is in the member's record that includes a statement regarding the member's appeal rights.
There is a copy of the written discharge/transfer notice is in the member's record that includes the name of the director of the Division of Administrative Law.
There is a copy of the written discharge/transfer notice is in the member's record that includes the current address of the Division of Administrative Law
There is a copy of the written discharge/transfer notice is in the member's record that includes the telephone number of the Division of Administrative Law.
There is a copy of the written discharge/transfer notice is put in the member's record that includes a statement regarding the member's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.
There is evidence of transfer or discharge planning conference with the member.
There is evidence of transfer or discharge planning conference with family (if applicable)
There is evidence of transfer or discharge planning conference with the case manager (if applicable)
There is evidence of transfer or discharge planning conference with the legal representative, if applicable
There is evidence of transfer or discharge planning conference with the advocate, if such is known.
There is evidence of developing discharge options that will provide reasonable assurance that the member will be transferred or discharge to a setting that can be expected to meet his/her needs
There is evidence of preparing an updated service plan, as applicable
There is evidence of preparing an updated written discharge summary that includes a summary of the health of the member.
There is evidence of preparing an updated written discharge summary that includes a summary of the **behavioral issues** of the member.
There is evidence of preparing an updated writtendischarge summary that includes a summary of the **social issues** of the member.
There is evidence of preparing an updated writtendischarge summary that includes a summary of the **nutritional status** of the member.
There is evidence of providing all services required prior to discharge that are contained in the final update of the service plan, as applicable.
There is evidence of providing all services required prior to discharge that are contained in the in the transfer or discharge plan.
There is evidence of a service plan is in the record.
There is evidence that the service plan was developled prior to delivery of services.

There is evidence that the service plan is updated at least every six (6) months, or more frequently based on changes to the member's needs or preferences.
There is evidence that the service plan was developed in collaboration with the member/member's family to include the frequency of each activity.
There is evidence that the service plan was developed in collaboration with the member/member's family to include the **duration** of each activity.
There is evidence that the service plan was developed in collaboration with the member/member's family based on the member's goals.
There is evidence that the service plan was developed in collaboration with the member/member's family based on member preferences.
There is evidence that the service plan was developed in collaboration with the member/member's family based on assessed needs.
There is evidence that the service plan was followed.
There is evidence that the PCS provider provided the plan to the member prior to service delivery
There is evidence that the PCS provider provided the plan to the member when the plan is updated
There is evidence that service logs document the PCS provided and billed.
There is evidence that service logs document any variation from the approved service plan with reason for variation.
There is evidence that service logs document the member's name.
There is evidence that service logs document name of direct service worker who provided the service
There is evidence that service logs document assistance provided to the member.
There is evidence that service logs document the date of service
There is evidence that service logs document the place of services
There is evidence that service logs are completed daily, as services are provided (may not be completed prior to services).
There is evidence that service logs are signed by the direct service worker after the work has been completed at the end of the week

There is evidence that service logs are dated by the direct service worker after the work has been completed at the end of the week
There is evidence that service logs are signed the member or responsible representative after the work has been completed at the end of the week
There is evidence that service logs are dated by the member or responsible representative after the work has been completed at the end of the week
There is evidence that service logs are specific to only ONE member.
There is evidence of a back-up staffing plan in the event the assigned direct service worker is unable to provide support due to unplanned circumstances or emergencies that may arise during the direct service worker's shift
There is evidence that available options for back-up coverage were discussed with the member or his/her authorized representative and complete the required staffing plan
There is evidence that the back-up plan includes person or persons responsible for back up coverage (including names, relationships, and contact phone numbers)
There is evidence that the back-up plan includes a toll-free telephone number with 24-hour availability that allows the recipient to contact the provider if the worker fails to show up for work
There is evidence that the back-up plan includes member signature
There is evidence that the back-up plan includes provider signature
There is evidence that the back-up plan includes date
There is evidence that the direct care worker contacted the provider when not able to provide services
There is evidence that the direct care worker contacted the family/member immediately, when not able to provide services.
There is evidence that the back-up plan is current.
There is evidence that the back-up plan is being followed according to the plan.
There is evidenceof an individualized emergency plan in preparation for emergencies and disasters that may arise
There is evidence of an individualized emergency plan responses to emergencies and disasters that may arise
There is evidence of an individualized emergency plan documents specific resources available through the provider, natural resources, and the community
There is evidence that the emergency plan is assesd on an ongoing basis whether the emergency plan is current and being followed according to the plan
There is evidence that the emergency plan is signed by the member
There is evidence that the emergency plan is signed by authorized representative
There is evidence that the emergency plan is signed provider.
There is evidence that the emergency plan is dated by the member
There is evidence that the emergency plan is dated by the authorized representative
There is evidence that the emergency plan is dated by theprovider.
There is evidence that PCS does not include administration of medication
There is evidence that PCS does not include insertion and sterile irrigation of catheters

There is evidence that PCS does not include irrigation of any body cavities which require sterile procedures
There is evidence that PCS does not include complex wound care
There is evidence that PCS does not include skilled nursing services as defined in the State Nurse Practice Act.
There is evidence that services are provided in home and/or community- based settings
There is evidence that services are not provided in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of personal care services
There is evidence that services are not provided in the direct service worker's home
There is evidence that services are not provided in a nursing facility, Intermediate Care Facility for the Developmentally Disabled, Institute for Mental Disease, or other licensed congregate setting
There is evidence that PCS are not provided while the member is attending or admitted to a program or setting that provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided
There is evidence that IADLs are not performed in the member's home when the member is absent from the home. Exceptions may be approved by the Medicaid managed care medical director on a case-by-case, time-limited basis
There is evidence that PCS are not billed during the time the member has been admitted to a hospital, nursing home, or residential facility. Services may be provided and billed on the day the member is admitted to the hospital and following the member's discharge
There is evidence that PCS does not supplant care provided by natural supports
There is evidence that PCS does not include room and board, maintenance, upkeep, and/or improvement of the member's or family's residence
There is evidence that PCS is not provided outside the state of Louisiana unless a temporary exception has been approved by the Medicaid managed care entity
There is evidence that services are not provided by biological, legal or step first, second, third or fourth degree relatives
There is evidence that services are not provided by first-degree relatives include parents, spouses, siblings, and/or children
There is evidence that services are not provided by second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and/or nieces
There is evidence that services are not provided by third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and/or first cousins
There is evidence that services are not provided by fourth-degree relatives include great-great grandparents, great-great grandchildren, and/or children of first cousins
There is evidence that services are not provided by curator, tutor, legal guardian, authorized