BEHAVIORAL HEALTH - CLINICAL UTILIZATION REVIEW (CUR) (Peer Format)

Client Name/ #: _______________________________

Clinician Name: *Megan Schomer* *Susan Killeen*

Clinic Site: *Hemetite* *Gray Summit* *St. Clair* *Sherwood* *Windsor*

Reviewer: *Stephanie Kerth* *Megan Schomer* *Susan Killeen*

Signature of Reviewer: ___________________________________

Date of Review: _______________________________

Review Question	Yes	No	N/A	Comments/Clarification
Initial/Annual Assessments				
1. Is there a thorough assessment that includes identified problem, key symptoms, mental status, and risk?				Clinical formulation is complete, key symptoms identified in very specific focused way, connection to function is clear, and linkage of key psychosocial factors are included. Documentation is thorough enough to justify the reason provider arrived at both primary and secondary diagnosis.
2. Is substance use thoroughly assessed?				Documentation is thorough enough to support the assessment conclusions.
3. Is the current DSM diagnosis (including DLA-20 score) documented and consistent with assessment?				DSM diagnosis along with DLA-20 score must be included and must be supported by the body of the assessment.
Treatment Plan (initial/master)				
4. Is there an initial/master treatment plan which includes relevant specific goals and appropriate interventions?				Treatment plan is present that documents goals and interventions relevant to the findings in the assessment. Goals focus on key target symptoms and connect it to function. Interventions are specific, clear, and behaviorally based. If substance use has been identified, is there a plan to address the needs in subsequent visits or referrals made?
5. Do Treatment Plan Reviews reflect the need for continued service or a change in level of care?				Progress towards goals is demonstrated and indicate the need for continued service or change in level of care.
For Progress Notes				
6. Is client's response to treatment interventions documented?				Response to treatment is present and written in specific behavioral terms describing patient initiated and provider initiated actions.
7. Is client's progress towards goals documented?				Progress toward goals is documented. Progress is specific, clear, symptom focused with connection to function. If no progress, are reasons for lack of improvement clear and, when appropriate, a change in treatment recommended?
8. Are plans for follow-up treatment or discharge documented?				Plans are specific and clear including return visit interval.
For All Visits				
9. Did clients with identified risk factors (i.e. depression, alcohol/drug use, suicidal ideation), receive a risk assessment and appropriate treatment and/or referral to the appropriate level of care?				Risk assessment is complete including key areas of ideation, plan, and intent as well as clinician assessment of risk. Next steps in treatment are clear and optimal for the patient and noted throughout treatment until risk has been alleviated.
10. Does the record reflect continuity and coordination of care with other medical providers (i.e. primary care, dental, hospitals) as well as other community providers (i.e. Children's Division, P&P, Juvenile Office, Schools)?				Is there documentation that provider has coordinated their treatment plan with other members of the treatment team (internal and external to the agency)? If not, is there documentation that the patient does not want providers notified?

Review Question	**Yes**	**No**	**N/A**	**Comments/Clarification**
11. Frequency of contact is consistent with diagnosis and severity of symptoms?				
12. Client continues to need services.				
13. Client is receiving appropriate level of care.				
14. High Risk? (No use of N/A)				Definition for Risk Assessment below.

Adult:
-Psychiatric inpatient treatment within the past 6 months/or multiple (2+) in past year
-Changing residential status (residential to independent living, or vice versa)
-Substance use/abuse, including recent discharge from a residential treatment program
-Homelessness or impending homelessness
-Suicidal ideations or homicidal ideations, statements, or behaviors within last 6-9 months
-Pregnant women
-Intravenous drug users who have injected drugs in the prior 30 days
-Civil involuntary commitments
-Department of Corrections institutions/Probation and Parole clients who have been classified as "DOC High Risk" based on the DOC assessment
-Applicants and recipients of Temporary Assistance for Needy Families (TANF),
referred by the Department of Social Services, Family Support Division, via referral form and protocol
-Adolescents and families served through the Children's System of Care

Youth:
-Child being removed from their home into a psychiatric inpatient hospital within the past 6 months/or multiple inpatient hospitals within the past year.
-Recent discharge from a residential setting or Treatment Family Home,
-Suicidal ideations or homicidal ideations, statements or behaviors within the last 6 to 9 months.
-A child having current or (within the past 6 months) juvenile or Children's Division involvement
-Current Traumatic event
-History of violent behavior
-Homeless
-Current substance use
-Pregnant or teen parent
-Intravenous drug users who have injected drugs in the past 30 days
-Suicidal or homicidal ideations, statements or behaviors within the past 6-9 months
-Current traumatic event
-History of violent behavior

IN ACCORDANCE WITH JFCAC'S CLINICAL UTILITATION REVIEW POLICY, *(AND SECTION 9 CSR 10-7.040 OF MISSOURI REGULATION),* THIS RECORD IS DETERMINED TO HAVE:

____ No Deficiencies Noted

____ Deficiencies noted for reasons related to documentation requirements only

____ Deficiencies noted for reasons related to treatment services, *such as clinical eligibility for services, adequacy of program planning and assessment, appropriateness of goals and objectives targeted, and/or the likeness the treatment plan will produce the desired outcome*

___ Deficiencies notes for *both* documentation requirements and treatment services

ACTION TO BE TAKEN:

☐ No further action needed
☐ Corrective Action Plan
☐ Modification of Treatment Services
☐ Modifications Submitted to Billing Department

☐ Action to Be Taken is to be completed by the following date: __________

______________________________ _____________
Signature - Reviewed by Clinician Date

______________________________ _____________
Signature – Reviewed by Supervisor Date

______________________________ _____________
Signature- Reviewed by CIO Date

FOLLOW UP: (to be completed upon correction of deficiency)

☐ Action to Be Taken has been completed on: _____________
Date completed

______________________________ _____________
Signature - Clinician Date

______________________________ _____________
Signature –Supervisor Date

______________________________ _____________
Signature- CIO Date