MSHN
Mid-State Health Network

2024 SUDSP Clinical Chart Review Tool

#	Standard/Elements	Source/Basis	Evidence May Include	Review Guidelines	**Provider to complete:** List evidence provided and where to locate such as page number or highlighted text in document
Screen/Admission/Assessment					
1.1	At point of initial contact, the following information is accurately documented in the REMI Level of Care Determination • Date of initial contact • Presenting Issue • Priority Population Status • Eligibility Determination • ASAM Level of Care Determination • MDOC referred individuals provided assessment regardless of screening documentation • CFJ 306 & MDHHS 5515 are present at time of referral	PIHP Contract; Access System Standards	Consumer Chart REMI Brief Screening and Level of Care Determination	Priority Population includes MDOC Brief Screening and LOC Determination are complete in client chart in REMI; Date of First Request in REMI is accurate according to when client called for service NOT the date client was admitted; Provider is not using their own "homegrown" screening tool and entering REMI data after the client is admitted	
1.2	For individuals who do not have Medicaid/Healthy Michigan Plan the Financial Information (Block Grant Only) • Verification of Income • Evidence the provider has offered to assist the consumer in applying for Medicaid/Healthy Michigan Plan	MSHN Contract SUD – Income Eligibility and Fee Determination Procedure	Consumer Chart. Signed MSHN SUD income eligibility and fee agreement determination procedure; Case Management Notes/Referrals	*Block Grant Financial Eligibility Form is complete, and a copy saved in client chart and/or REMI if client is using BG funding *Evidence Medicaid/HMP application has been submitted in the first 30 days of service in client chart and/or REMI if client is using BG funding	

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1.3	Evidence of screening for: • HIV/AIDS • STD/Is • TB • Hepatitis and • Trauma • FASD	MSHN Contract, Prevention Policy # 02	Provider Intake/Assessment Forms	The provider is utilizing additional screening tools for communicable disease, FASD, and trauma OR these items are embedded in assessment. Clinical documentation should indicate what follow-up is recommended (and occurs) as a result of positive screening. At a minimum the communicable disease screening must contain the required questions from the Prevention Policy #2. If communicable disease screening occurs and a referral is indicated and not made, standard is partially met.	
1.4	Evidence consumer has received information regarding: • General nature and objectives of the program • Notice of Privacy • Consent to Treatment For MAT-Pregnant women Consent/All women consent • Advanced Directives • Member Handbook • SUD Recipient Rights • Unless notified (in writing) prior to admission, a recipient may utilize medications as prescribed by a physician.	R 325.14701. R 325.14305(3) 42 CFR § 438(g)(1). MSHN Contract 42 CFR 438.6 Admin. Rule R325.1397(4) R 325.1393 (3)	Consumer chart Recipient Rights understanding form (required) Handbook receipt/offer form (chart note)	This can include separate signed documents or a checklist of the documents the person received.	

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1.5	The ASAM Continuum (adults) GAIN I-Core (adolescents) is the only assessment tool used. Initial assessment and/or timely reassessment contains required elements: • ASAM Level of Care-Determination is justified and meets the needs of consumer. • Provisional DSM Diagnosis • Clinical Summary • Recommendations for Care	BSAAS Policy #09, 10, and 13 PIHP Contract	Consumer Chart	Re-assessment should be completed annually	
Individual Treatment/Recovery Planning and Documentation					
2.1	The amount, scope, and duration for all authorized services are identified in the treatment/recovery plan and appropriate for consumer's needs, objectives, and goals.	BSAAS Policy #06 MSHN SUD Provider Manual, Medicaid Manual; LARA SUD Admin Rule 325.1363 (3)(b)	Treatment plan & REMI Authorization(s)	Amount, scope, and duration should align with what is being requested in authorizations.	
2.2	Initial treatment plan is developed before consumer is engaged in extensive therapeutic activities: • Outpatient – during/before 2nd session • OTP Methadone – within 24 hours of admission • Residential – within - 24 hours of admission • Detoxification – within 24 hours of admission	MSHN SUD Provider Manual, Individualized Treatment Planning section. LARA SUD Admin Rule R 325.1363 (a) and (b)	Initial Treatment Plan with Date & Signatures _ Corresponding Progress Note(s)	The plan must meet all statutory and treatment policy requirements. Interim plans are not acceptable and should not be used to bypass the required timelines.	

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2.3	Plan(s) address needs/issues identified in assessment(s) (or clear documentation of why issue is not being addressed) including but not limited to: • Substance Use Disorder(s) • Medical/Physical Wellness • Co-Occurring D/O • History/Risk/Present Trauma • Gambling	BSAAS Policy #06 p.2, #1; MSHN SUD Provider Manual	Treatment plan Assessment Needs Assessment Screen(s) – Trauma, Co-Occurring (did results indicate a need for action on a treatment plan)		
2.4	Treatment/Recovery Plan is individualized and includes the following: 1. Goals are expressed in the client's words and are unique to the client- No standard or routine goals that are used by all clients. 2. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc. 3. Signatures – client, counselor, and involved individuals, or documentation as to why no signature.	BSAAS Policy #06 p.3, MSHNSUD Provider Manual	Treatment plan	Treatment plans should cover all dates of services being requested. Goals & Objectives should not have all the same target & completion dates. No standard or routine goals that are used by all clients.	
2.5	Goals and objectives are written using SMART criteria. (S- Specific, M- Measurable, A- Attainable, R- Relevant, T- Time-bound)	MSHN SUD Provider Manual	Treatment Plan		

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2.6	Frequency of periodic reviews of the plan are based on the time frame in treatment and any adjustments to the plan. Outpatient – ASAM 1.0 LOC – minimally 90 days Outpatient ASAM 2.1 LOC – minimally 30 days ASAM 2.5 LOC – minimally 14 days Residential ASAM LOC's - minimally 14 days	MSHN SUD Provider Manual BSAAS Policy #06 LARA R 325.1363 (4)	Treatment plan reflects timely review.	Withdrawal Management (if applicable) – if medically necessary submit an updated plan based on medical necessity.	
2.7	The treatment and recovery plan progress review includes: 1. Progress note information matching what is in review. 2. Rationale for continuation/discontinuation of goals/objectives. 3. New goals and objectives developed with client input. 4. Client participation/feedback present in the review. 5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature	BSAAS Policy #06, p 3- 5; MSHN SUD Provider Manual	Treatment plan(s) & reviews include consumer signature with date, consumer feedback (specifically the reviews), etc.	Ensure "as evidenced by" is utilized for justification of changes / no changes to services. Simply writing "doing good" is not enough justification.	

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2.8	An evidence-based practice was used and documented in the record for trauma in response to a positive screening outcome.	MSHN Provider Manual MDHHS BHDDA Trauma Policy	Assessment Progress notes Other documentation in the record	Only include evidence-based practices for trauma. Other EBPs are included in a separate standard. Please identify the evidence-based practice in the comment box that was used in the record. Mark "yes" if an evidence-based practice was present. Mark "no" if there was not an evidence-based practice in the record. If not positive outcome- "NA"	
2.9	An evidence-based practice was used and documented in the record.	MSHN Provider Manual, MDHHS QAPIP Policy	Assessment Progress notes Other documentation in the record Screening tools	Do not include evidence-based practices for trauma as it is included in a separate standard. Please identify the evidence-based practice in the comment box that was used in the record. Mark "yes" if an evidence-based practice was present. Mark "no" if there was not an evidence-based practice in the record.	
Record Documentation and Progress Notes					
3.1	Progress notes reflect information in treatment plan(s): • Identify what goal/objective(s) were addressed during a treatment session • Individual and group sessions that the person participates in must address or be related to the goals and objectives in the plan Document progress/lack of progress toward meeting goals.	BSAAS Treatment Policy #06, p. 3 of 5.	Documented progress notes reflect relationship to goals and objectives in the treatment plan.	For occasions in which goals were not addressed (i.e., crisis), document reason.	

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3.2	Services are provided as specified in the plan(s).	Medicaid Provider Manual 2.2 Substance Abuse Services	Progress notes demonstrate the services are provided, as indicated on the consumer's Individual plan of service.	Notes are reflective of authorized services and match plan. No shows and cancellations are documented. Amount, scope, and duration of services provided is commensurate with plan or there is documentation if services are provided differently than specified in plan.	
3.3	Consumer strengths are identified within the record and used to drive the person-centered planning process.	BSAAS Policy #06 p 2 of 5; MSHN SUD Manual	Assessment, Treatment Plan		
Coordination of Care					

4.1	There is evidence of primary care physician coordination efforts. If the client does not have a primary care provider, there is documentation that they were offered information and referral to a provider of their choice.	PIHP Contract; MSHN Provider Manual, MSHN Treatment Contract Treatment Policy #5	Consumer file, documented communication/coordination	Evidence must include a signed release of information for the primary care provider, including name and contact information, or documentation of the client's refusal to provide consent. Must use required release form ONLY– must have contact info. Off-dosing, including Sundays and holidays, is not allowed without coordination of care (or documented efforts). This includes controlled medication prescribers for people enrolled in MAT and the approval of use of medical marijuana by physician (if applicable) and documented in nurse's notes or doctor's notes. . To demonstrate primary care coordination, the provider should minimally send a communication to the physician notifying them of the person receiving SUD services and have documented attempts to coordinate physical/medical care needs with the physician, as appropriate in the persons agency record. Evidence must include a signed release of information for the primary care provider, including name and contact information, or documentation of the client's refusal to provide consent. Must use required release form. Must have evidence of coordination/attempted coordination. A signed consent alone is not sufficient if there is no evidence of SUD provider efforts to exchange information.	
4.2	There is evidence of the required release of information (MDHHS Consent) form being	MSHN Treatment Contract	Completed Consent forms		

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	used and completed as required for all coordination.	MSHN Consent to Share Policy			
4.3	There is evidence of coordination of care with external entities including, but not limited to, the legal system, child welfare system, behavioral healthcare system. Documentation of coordination of care may include phone calls, non-billable progress notes, letters, emails, etc. A signed release of information is not sufficient to document coordination of care. MDOC referred individuals have evidence of at least monthly coordination (sent by the 5th day of the following month) between agency and supervising agent	MDHHS Contract; SUD Provider Manual	Consumer file, MDOC Monthly Progress Report	Ensure provider is documenting coordination of care efforts. This should include phone calls, emails, meetings, etc. There should be coordination with all relevant parties as is needed for support of consumer's treatment/ engagement/recovery.	
4.4	There is evidence of effective coordination between transitions from one provider or level of care to another. Evidence should include sharing of any ASAM Continuum/Gain I-Core assessments and may also include treatment plans and discharge information that improves care and reduces redundancy for the person served.	MSHN SUD Provider Manual, MSHN SUD Tx contract p.34 (6)	Consumer file	Required for consumers entering services from another provider or level of care. Providers should send/request assessments, discharge(s), treatment plans and any other documents relevant to care that would reduce redundant work.	
4.5	There is evidence that provider makes appropriate referrals and documents follow-up and outcomes, as is applicable to meet the consumer/family needs.	LARA SUD Administrative Rules R 325.1359 R325.1363 (c), MSHN SUD Provider Manual	Consumer Chart	When needs are identified there should be services provided to meet the needs. If the provider does not offer the services, a referral to an agency that offers the services should be made.	

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Discharge/Continuity in Care					
5.1	Discharge Summary includes all Continuum of Care Detail(s) including next provider contact information, date/time of intake appointment, relevant information etc. • Discharge from Detox/Withdrawal Management Unit requires documentation of a follow up appointment to occur within 7 days of the date of discharge.	MSHN SUD Provider Manual, PIHP Contract, MDHHS Michigan Mission Base Performance Indicator System	Discharge Summary	WM only.	
5.2	MDOC referred individuals have evidence of the following (with appropriate release): • Provider will ensure a recovery plan is completed and sent to the supervising agent within five (5) business days of discharge- plan must include individual's knowledge of plan and any aftercare services • The provider will ensure documentation of informing the client's supervising agent prior to any discharge due to violation of program rules/regulations except in extreme circumstances. • The provider will collaborate with the supervising agent for any non-emergency discharge of the referred individual and allow the MDOC time to develop a transportation plan and/or a supervision plan prior to removal.	PHIP Contract, MSHN SUD Treatment Contract	Consumer file, progress notes, discharge summary	Evidence that recovery plan was sent to supervising agent (i.e.: email/fax confirmation, communication notes in consumer chart, etc.)	

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5.3	Consumer's treatment episode is summarized including: • Status at time of d/c (Status may include prognosis, stage of change, met & unmet needs/goals/objectives, referrals &/or follow-up information) • Summary of received services/ participation • Discharge rationale is clearly & accurately documented	MSHN SUD Provider Manual	Consumer file includes discharge summary with required status and condition described. Discharge summary clearly indicates rationale.		
Residential					
6.1	**Residential withdrawal management** At the time of admission and prior to any medications being prescribed or services offered, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history, as well as a physical examination, of the recipient. **Residential** The recipient record for residential service categories shall also include medical history and physical examination	R 325.1361(3)(a) R 325.1361 (2)(a) R 325.1393 (3)	Copy of medical exam is included in the client chart.	Verify the date of medical history and examination are prior to the first date of medication being dispensed for new medications. Withdrawal Management- Verify date of medical history and examination are prior to services being provided.	

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6.2	**Residential Treatment** Provider must assure all consumers entering residential treatment will be tested for TB upon admission (within 24 hours) and the test result is known within five (5) days of admission	MSHN Provider Contract, Attachment A: Statement of Work Prevention Policy #2 (page 3, Item 3)	Copy of TB testing & results is included in the client chart.	Verify TB test is included in the record.	
6.3	**Residential Treatment** Sentinel events – unexpected death, overdose, challenging behavior, arrest, injuries and / or medication errors resulting in emergency treatment or hospitalization should be reported with documentation of follow up to prevent recurrence.	MDHHS Critical incident reporting event notification requirements MSHN Treatment Contract MDHHS QAPIP Policy	Incident report, progress note	If an event is noted in the chart, has it been reported to the PIHP through REMI. If the reviewer sees an event in the chart, verify that it was reported to MSHN via REMI. Reviewer- see provider dashboard- Provider Sentinel events	

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6.4	MDOC Referred Individuals ONLY (with proper release): • Individual referred does not appear or is deemed to not meet residential medical necessity the provider will notify the supervising agent within one (1) business day • Referred individual may not be given unsupervised day passes, furloughs, etc. without consultation with the supervising agent. • Leaves for any non-emergent medical procedures should be reviewed/coordinated with the supervising agent • If a MDOC referred individual leaves an off-site supervised therapeutic activity without proper leave to do so, the provider must notify the supervising agent by the day on which the event occurred. • The PIHP/designated provider may require individuals participating in residential treatment to submit to drug testing when returning from off property activities and any other time there is a suspicion of use. Positive drug test results and drug test refusals must be reported to the Supervising Agent.	PIHP Contract, MSHN Contract	Client Chart documentation	If none of the conditions exist, then it should be N/A. The contract does not specify how these items are documents just that they are so evidence could be anything in the chart.	

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6.5	MDOC-Additional reporting notifications for individuals receiving residential care include: • Death of an individual under supervision. • Relocation of an individual's placement for more than 24 hours. • The PIHP/designated provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves. • The PIHP/designated provider must notify the MDOC Supervising Agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity.	PIHP Contract, MSHN Contract MDHHS Critical Incident Reporting and Event Notification	Client Chart documentation	If none of the conditions exist, then it should be N/A. The contract does not specify how these items are documents just that they are so evidence could be anything in the chart.	
Medication Assisted Treatment					

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7.1	Before any medications are prescribed, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history and physical examination of the recipient. In addition, any modification to medications or course of treatment must be documented in the recipient record and ordered by a physician, physician's assistant, or advanced practice registered nurse.	R 325.1383(9) MDHHS TX Policy 5 42 CFR 8.12	Copy of medical exam is included in the client's chart.	All MAT services. Copies of med exam in record. TX History Meds IV Use Pregnancy/Childbearing Age STI's	
7.2	OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and monthly random tests on each patient.	R 325.1383 (14)(a-e)	Clinical documentation in client's chart	All UDS results must be uploaded into REMI within 24 hours. (Needed for auth/re-auth purposes.) THC without medical marijuana card is considered illicit use of substance. Providers will conduct medically necessary toxicology screens for all people receiving medication for substance use not to exceed 8 unless appropriate clinical/medical justification is provided. Tip 64 Drug screens are not the only way to determine diversion or illicit use.	

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7.3	Suboxone and Methadone: Documented review of Michigan Automated Prescription System (MAPS) is included in the client file at admission, prior to any off-site dosing, and prior to any reauthorization requests. Note: Per MDHHS guidance, the MAPS report cannot be placed in the individual's chart. Information can be documented in the chart.	MDHHS Policy #05, page 5 of 11, MSHN SUDSP Manual	Clinical documentation in client's chart	Documentation of MAPS report outcomes in chart. MAPS conducted at intake. Look for counter-reactive meds. Phase change also should result in MAPs. Physical – includes MAPs. Be aware of over-the-counter meds and document in case of disputed test results (meds causing false negatives can be easily checked sometimes)	
7.4	ALL MAT: All alcohol use and illicit drug use during treatment is addressed in treatment and documented in Progress Notes.	BSAAS Treatment Policy #05, p. 7, MSHN SUDSP Manual	Clinical documentation in client's chart. Drug screen outcomes, indicating illicit use, are addressed immediately and communication is documented.	THC without medical marijuana card is considered illicit use of substance.	
7.5	All MAT: Documentation that the MAT Provider, as part of the informed consent process, has ensured that individuals are aware of the benefits and hazards of methadone treatment.	BSAAS Treatment Policy #05, p. 4 of 11.	Clinical documentation in client's chart	Should be signed and in consumer record. Generally found as part of the intake paperwork. Checklist w/ initials also acceptable.	
7.6	METHADONE ONLY: Documentation of a client-signed consent to contact other OTPs within 200 miles to monitor for enrollments in other methadone programs.	BSAAS Treatment Policy #05, p. 4; 42 CFR 8.12(e)	Clinical documentation in client's chart	Documented during intake paperwork, accompanied by release form allowing the enrollment check.	
7.7	METHADONE ONLY: Evidence take-home doses are occurring in accordance with regulations.	R 325.1383(15)(a-c) BSAAS Treatment Policy #05, p. 4 of 11	Clinical documentation in client's chart	EMR may track dosing info. Consumers sign for dosing, etc. Records should flag consumer's meeting take home criteria requirements.	

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7.8	MDOC Referred Individuals ONLY (with appropriate release): provider informs the Supervising Agent when Medication Assisted Treatment (MAT) is being used, including medication type. If the medication type changes, the Supervising Agent was informed.	PIHP Contract, MSHN Contract	Client chart, progress notes, MDOC release of information		
Women's Designated					
8.1	There is an assessment of needs completed on consumer & each dependent child.	BSAAS Treatment Policy #12	Assessment Needs Assessment(s) for all Children in Care		
8.2	There is evidence of gender-specific service provision(s)	BSAAS Treatment Policy #12	Progress Notes and Individualized treatment plans in client files. Gender-Specific Service Provisions may include: *Relational Considerations Empowerment utilization in treatment & recovery planning *Employment Skill-building & other Survival Skills	Reviewer will see this in Accessibility, Assessment, Psychological Development, Abuse/Violence/Trauma, Family Orientation, Mental Health Issues, Physical Health Issues, Legal Issues, Sexuality/Intimacy/Exploitation, Survival Skills, Continuing Care/Recovery Support	
Recovery Housing					

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9.1	Eligibility is confirmed via outpatient treatment engagement/attendance (no less than 1 time every 30-days).	MSHN Technical Advisory on Housing, NARR guidelines, MSHN SUD Provider Manual – Appendix B	Consumer charts Outpatient provider verification of admission (OPT provider REMI admission),	Recovery housing provider must ~~t~~ verify attendance & engagement w/ outpatient provider.	
9.2	Resident chart includes the following information: Standard demographic information Releases of Information (MSHN, Medical, Treatment Provider, Emergency Contact) Signed Acknowledgement of Rules	NARR guidelines MSHN SUD Provider Manual Appendix B	Consumer charts	Consents must be on the State approved template & clearly completed. MUST have consents for SUD treatment provider, emergency contact, PCP Rules signed/dated in chart.	
9.3	Chart includes completed screen and application.	MSHN SUD Provider Manual	Consumer charts	Resident initial screen & application should be in the record. Screens must: • Health & Safety (Self-Harm, Homicidal, Harm to Others) • Co-Occurring – asking about current mental health & meds Application Must: • Be used to assist with current resident input. • Be completed by the consumer (via phone or submission) • Be used for decision-making purposes regarding consumer's fit for provider housing programming	

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9.4	Service Plan includes the following: • Service amount, scope, duration • Efforts to achieve independent living arrangements. • Efforts to achieve a source of income • Evidence of Consumer involvement (individualized plan, 1st person language) • Signature/Date by Professional & Resident	MSHN SUD Recovery Housing Technical Requirement 2016, MSHN SUD Provider Manual, Appendix B	Consumer charts	Must include the plan/steps for independent housing (pertaining to consumer). Why does consumer not have housing and what is plan? Amount/scope/duration – what services, when & for how long. Must match authorization & reauthorization in REMI. Documentation of efforts to achieve a source of income. What actions/steps are being taken to ensure the person has sustainable income after discharge?	