Department of Public Health
Office of Compliance Privacy Affairs (OCPA)

SUD AUDIT TOOL Outpatient Services (OS) Intensive Outpatient Treatment (IOT) Residential (RES)
Audit Date:
Program/RU #:
Reviewer:
Date Reviewed:

Client Name:
BIS#:
Episode Opening Date:
Date of Service (DOS):
Service Type/Code:
TPOC Effective Date:
Date TPOC Ends:

#	Comments

Department of Public Health
Office of Compliance Privacy Affairs (OCPA)

FATAL			
DIAGNOSIS			
No.	**Type**	**Audit Item**	**Y/N/NA**
1	DX	Does the client have a valid DSM-5 Substance-Related and Addictive Disorder, other than a tobacco-related or non-substance related disorder? *(IA Exhib. A Att. I A2 (III)(B)(2)(ii)(a))*	
2	DX	Is there documentation of the LPHA meeting with the counselor who conducted the assessment, or did the LPHA conduct the assessment? *(IA Exhib. A Att. I A2 (III)(PP)(10)(i))*	
ASAM			
3	ASAM	Has the ASAM level of care been determined by an LPHA? *(IA Exhib. A Att. I A2 (III)(B)(2)(iv))*	
4	ASAM	Timing of the ASAM level of care: i. If the most recent ASAM level of care was done during the client's intake, was the level of care made after the diagnosis (diagnosis must come before the ASAM LOC) ii. Was the ASAM level of care completed within six months of the claim? *(IA Exhib. A Att. I A2 (III)(B)(2)(v))*	
5	ASAM (RES)	**For Residential Programs:** Has pre-authorization been obtained prior to the treatment?	
No.	**Type**	**Audit Item**	**Y/N/NA**
TREATMENT PLAN (TPOC)			
6	Initial TPOC	**For initial treatment plan** If the treatment plan was completed during intake, was that treatment plan signed by the **counselor or LPHA within 30 days** of admission? **AND** *(IA Exhib. A Att. I A2 (III)(PP)(12)(i)(b))*	
		For initial treatment plan Is there a LPHA co-signature **within 15 days** of the counselor's signature? (This is needed to attest that the services are medically necessary and appropriate for the client.) *(IA Exhib. A Att. I A2 (III)(PP)(12)(i)(b))*	
7	Updated TPOC	**For the updated treatment plan** Is there a counselor or LPHA signature within 90 days of the claim? *(IA Exhib. A Att. I A2 (III)(PP)(12)(i)(b))*	
		For the updated treatment plan Is there a LPHA co-signature **within 15 days** of the counselor's signature? (This is needed to attest that the services are medically necessary and appropriate for the client.) (IA Exhib. A Att. I A2 (III)(PP)(12)(i)(b))	
CONTINUING SERVICES JUSTIFICATION			
8	CSJ	**If the client has been in treatment for more than six months**, is there a Continuing Services Justification completed by a LPHA every six months? *(IA Exhib. A Att. I A2 (III)(B)(2)(v))*	

Department of Public Health
Office of Compliance Privacy Affairs (OCPA)

PROGRESS NOTES			
No.	**Type**	**Audit Item**	**Y/N/NA**
9	PN	Is the service provided in the claim part of the treatment plan? *(IA Exhib. A Att. I A2 (III)(PP)(12)(i)(a)(i)(5))*	
10	PN	Is there a name, signature, and date from the LPHA or counselor conducting the session? *(IA Exhib. A Att. I A2 (III)(PP)(15)(i)(a)(i))*	
11	PN	Are any group progress notes supported by group sign-in sheet that contains: A. A name, signature, and date from the LPHA or counselor conducting the session. ___ B. The date of the counseling session. ___ C. The topic of the counseling session. ___ D. The start and end time of the counseling session. ___ E. The typed or legibly printed name of each participant with their signatures. ___ *(IA Exhib. A Att. I A2 (III)(PP)(13)*	
POTENTIALLY FATAL			
No.	**Type**	**Audit Item**	**Y/N/NA**
PF-1	Initial and Updated TPOC	**For both Initial and Updated Treatment Plan** If the treatment plan was completed during intake, was that treatment plan signed by the client within 30 days of admission. If the client refuses to sign the treatment plan, has the provider documented why and what the provider's plan is to engage the client in treatment? (Claims provided according to unsigned plans will be voided) *(IA Exhib. A Att. I A2 (III)(PP)(12)(i)(b))*	
PF-2	PN	**Progress Notes** must be completed, signed, and dated within seven calendar days of the service and must contain: A. The beneficiary's name. ___ B. The purpose of the service. ___ C. A description of how the service relates to the client's treatment plan problems, goals, action steps, objectives, or referrals. ___ D. The date, start and end times of each service. ___ E. Whether the services were provided in-person, by telephone, or by telehealth. ___ F. If services were provided in the community, the location and how the provider ensured confidentiality. ___	
PF-3	PN (IOS and RES)	**Progress Notes** Instead of a progress note for each session, IOS and RES programs may have one progress note a week that contains: A. For IOS and RES programs, is there a billable service that includes a LPHA or counselor signature? ___ B. Is there A billable service for each day that was charged to Medi-Cal. ___ *(IA Exhib. A Att. I A2 (III)(PP)(14)(i)(b))*	