PRSN Review Tool: Intake and Reauth	
Review Period	
PRSN Reviewer	
Provider	
Client ID	
Axis 1	
Axis 2	
Axis 3	
GAF	

Intake Requirements (Do on Intake Reviews ONLY)				
Date of Request for Services				
Date of Intake				
Days Between Request and Intake	**0**			
Date of First Routine service				
Days Between Request and First Routine Service	0			
Enter 1 if the service occurred within 28 days, 0 otherwise				
	Score	**Possible Points**	**Percentage**	**Comments**
If routine service did not occur within 28 days there is adequate documentation explaining why (zero, 2, or n/a)		0		Performance Measure
The intake was completed by a Mental Health Professional		0		
The intake incudes the presenting problem as described by the individual.		0		
There is sufficient information to demonstrate medical necessity.		0		
The intake includes sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM) criteria.		0		
The intake includes a recommendation of a course of treatment.		0		
The intake includes input from people who provide active support to the individual, if the individual so requests, or if the individual is under thirteen years of age.		0		

The intake is culturally and age relevant.		0		
The intake includes the current physical health status, including any medications the individual is taking.		0		
If the individual does not have a PCP, they are referred to one. If there is a PCP, the name is documented.		0		
The intake documents any disabilities or special needs.*		0		
The intake documents history of substance abuse and treatment.*		0		
The intake documents any previously accessed inpatient or outpatient services and/or medications to treat a mental health condition.*		0		
The intake includes information about past or current trauma and abuse.		0		
The intake includes a description of the individual's strengths and resources.*		0		
There is a description of the individual's self-identified culture.*		0		
The intake indicates whether they are under the supervision of the department of corrections.		0		
There is an identification of risk of harm to self and others, including suicide/homicide;		0		
* Not required in intake. Can be included in Clinical Documentation at a later time.				
Clinical Documentation (Intakes Only)				
Client signature indicates he or she received the PRSN Consumers Rights (outpatient), Consent for Treatment, and Grievance/ Complaint forms.		0		
If interpreter services are needed there evidence in the progress notes they are provided		0		
The GAIN-SS is completed and in the record.		0		
Client signature indicates he or she was given information regarding Advance Directives, and was asked if he/she had one.		0		
WAC 388-865-0430 (3) Documentation that the provider requested a copy of and inserted into the clinical record if provided, any of the following: (a) Mental health advance directives; (b) Medical advance directives; (c) Powers of attorney; (d) Letters of guardianship, parenting plans and/or court order for custody; (e) Least restrictive alternative order(s); (f) Discharge summaries and/or evaluations stemming from outpatient or inpatient psychiatric services received within the last five years, when available.		0		

Release of Information completed for collateral and natural supports who are identified on the Intake or current progress notes, or there is documentation that consent has been refused. (not required to have a signed ROI for PCP in order to coordinate care)		0		
If information has been released, there is a current release of information on file consistent with HIPAA requirements for authorizing the disclosure.		0		
If the client did not receive a first routine appointment within 28 days, engagement efforts were adequate and appropriate to the Consumer		0		
Clinical Documentation (All Charts): Six Months Documentation Unless Otherwise Indicated				
IF Applicable, documentation that services are provided by or under the clinical supervision of a mental health specialist **(IF MEETS SPECIAL POPULATION REQUIREMENTS)**		0		ONLY SCORE IF A CHILD OR SPECIAL POPULATION
The clincial record indicates objective progress toward established goals as outlined in the treatment plan; and		0		
IF applicable The clinical record indicates how any major changes in the individual's circumstances were addressed.		0		
IF applicable, documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 RCW has occurred;		0		
IF applicable, documentation that the department of corrections was notified by the provider when an individual is on a less restrictive alternative.		0		
There is documentation that the consumer and/or family members, and natural supports (with permission from the consumer) were provided information and education about the consumer's illness.		0		
Notes identify treatment goal being addressed, and this goal is reflective of treatment plan.		0		
The notes document the consumer's current clinical/mental status.		0		
There is evidence in the clinical record that that the provider has supported consumer employment, education or participation in other daily activities appropriate to their age and culture;		0		
IF applicable, referrals were made to other needed services and supports, including treatment for co-occurring disorders and health care;		0		

There is documentation to explain any interruption or gap in service of 3 months or longer.		0		
REAUTH ONLY Communication with PCP has occurred within the **last year** either by sending medical notes, by documenting phone conversations, or by requesting notes from the PCP. (score only 2 or 0)		0		Reauth Only/Performance Measure
Medical Services Documentation (Consumers Receiving Medication Services Only)				
There is evidence of a psychiatric evaluation and it is reflective of why medication is prescribed.		0		
Medical progress notes include date, duration, type of service, and are signed, credentialed and legible.		0		
There is documentation that the consumer was given information about the medication(s) prescribed which included possible side effects, and it was provided in language understandable to the consumer.		0		
The clinical/medical record contains both the name and purpose of the medication prescribed, and clinical support for any change in medication and/or dosage.		0		
Effects and side effects of prescribed medications, as well as any interactions between medications, are documented in the record.		0		
The medications prescribed have been reviewed by the prescriber at least every 3 months.		0		
Treatment Planning (All Charts)				
The plan was initiated with at least one goal identified by the individual, or their parent or other legal representative if applicable, at the first session following the intake evaluation.		0		INTAKE ONLY
The full plan must was developed within thirty days from the first session following the intake evaluation.		0		INTAKE ONLY
Includes documentation that the individual service plan was reviewed at least every one hundred eighty days.It should also be updated to reflect any changes in the individual's treatment needs or as requested by the individual, or their parent or other legal representative if applicable.		0		REAUTH ONLY
The 180 day review includes a comprehensive assessment of the consumer's needs. **Note: For 2011-12 we are determining if the 180 day update in treatment plans is sufficient to mee the requirement. (EQRO finding: "More than 2/3 of the charts reviewed reflected comprehensive assessments that were more than two years old, and nearly one-third were more than five years old")**		0		REAUTH ONLY
The plan includes consumer strengths.		0		N/A if no treatment plan

The individual plan addresses the specific needs of this consumer. These are the needs that have been raised by the consumer, consumer supports, and the clinician in the intake and over the course of treatment. **If there is a need identified in the chart, there is a corresponding goal or objective,** or documentation as to why the need is not being addressed.		0		N/A if no treatment plan
Demonstrates the individual's participation in the development of the individual service plan using quotes from the individual. 0 = No evidence, 1 = Quotes in review only, 2 = Quotes in treatment plan problem statement or goal.		0		N/A if no treatment plan
Uses language and terminology that is understandable to individuals and their family.		0		N/A if no treatment plan
Includes treatment goals or objectives that are measurable and that allow the provider and individual to evaluate progress toward their identified recovery goals.		0		N/A if no treatment plan
Identifies medically necessary service modalities, mutually agreed upon by the individual and provider, for this treatment episode.	n/a	0		N/A if no treatment plan
Addresses age, cultural, or disability issues identified by the individual, or their parent or other legal representative if applicable, as relevant to treatment.		0		N/A if no treatment plan
With the individual's consent, coordinates with any systems or organizations the individual identifies as being relevant to the individual's treatment. This includes coordination with any individualized family service plan (IFSP) when serving children under three years of age.		0		N/A if no treatment plan
The person has a crisis plan (**2** if yes, **0** if person meets PRSN criteria for crisis plan requirements but does not have one. Otherwise, **N/A if not required**)		0		Adult: Any of these in last 2 years: Inpatient stay, suicide attemptt, violent act; Or, ITA eval in last 6 months; Or, current S/I or H/I; Or in residential services; Or assigned clinician/asessor believed it is nesessary. Child: Same as above or child's living situation is at risk.
N/A if not present. If present, does the crisis plan describe interventions that include resources of 1) the individual (such as coping skills), 2) natural supports (i.e. friends family,neighbors), and 3) institutional/systems (i.e. calling crisis clinic) as appropriate?		0		
As clinically relevant, the individulized service plan indentifies medical concerns and plans to address them. PIHP Provider Contract 12.8.2		0		N/A if no treatment plan
Utilization				
Assigned Level:				
Authorization Period:				
There is a current, active PRAT for the client in the data system.		0		

If the current PRAT is an initial one completed upon client enrollment, rate this item. Assigned Level is appropriate for client's diagnosis, GAF/CGAS score, symptomatology, and service needs and adheres to the guidelines in the current PRSN's Levels of Care.		0		Intake Only
If the current PRAT is for a continuing/renewed benefit, rate this item. Assigned level is appropriate for client's diagnosis, GAF/CGAS score, symptomatology, and service. Criteria used to determine re-authorization of an existing benefit adheres to guidelines in current PRSN Levels of Care. Continuation of service at assigned level is justified by documentation in chart of the client's clinical presentation as described in the treatment notes.		0		Reauth Only
If either 2a or 2b scored under 2 (the PRAT is "inappropriate,") score the following section.		0		
Enter "1" if level should be higher, otherwise leave blank		0		
Enter "1" if level should be lower, otherwise leave blank		0		
The frequency of service and type of service utilized is the best fit for this client, given the documented description of their clinical presentation in the treatment notes, and in the intake if it was completed within the previous year.		0		Note: Can be used to indicate under/over utilization, even when the PRAT is adequate.
EPSDT (Complete this section if client is under age 21)				
Evidence that facilitation of EPSDT services occurred for all children (0-21) adhering to the periodicity schedule, while brokering with multiple system providers to meet the identified needs of the child/family.		0		
Documentation exists that demonstrates communication with referral source (EPSDT medical provider), specifically written notice provided that includes at minimum: date of intake, diagnosis and level of care assignment.		0		
Written notification to child's medical provider (for children referred without EPSDT) requesting that documentation be provided that a Healthy Child screening has been completed or that one will occur. NA if client does not have a PCP.		0		
If no medical care provider is identified by enrollee, then a copy of EPSDT rights contained in the MHD benefits booklet is provided as well as assistance with selection/accessing of medical provider. NA if client has PCP.		0		
Develop an Individual Service Team (IST) including identified formal systems and natural supports for children authorized for Level II services and involved in two or more service systems (cross-system involved.)		0		
There is a cross-system Individual Service Plan (ISP) which addresses overall needs of both the child and family across life domains for cross-system Level II clients.		0		
Community Support (LRA) Scores (Only Consumers on LRAs)				
Either the individual service plan or a separate plan specifically addresses the conditions of the LRA order and plan for transition to voluntary treatment. WAC 388--865-046, 1d		0		

Consumer has signed LRA rights. WAC 388-865-0466, 1a		0		
If the consumer is on a 90-day or a 180-day LRA, the consumer has been evaluated monthly by an MHP with regard to release from or continuation of an involuntary treatment order. WAC 388-865-0245, 2a		0		

Other Comments:

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