APPENDIX ZP

ACT SERVICE AUDIT TOOL

AUDIT PERIOD:________________________

HSD REVIEWER:______________________________REVIEW DATE:_______________________

CLIENT NAME:________________________MEDICAID NUMBER:__________________________

DOB:________________________________AGE:____

Check the appropriate box and note comments in spaces provided.

	Yes	**No**
1. Does the client meet the eligibility requirements for participation in the ACT program?		
-Client is 18 years or older		
-A severe mental illness has been diagnosed (Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Psychotic Depression) by a licensed professional		
-Client has severe problems completing ADLs		
-Significant history of involvement in behavioral health services		
-Repeated hospitalizations and/or incarcerations		
-Frequent use of emergency services		
2. A comprehensive assessment, establishing medical necessity was completed within 40 days of client admission to ACT Program		
3. The file contains a culturally relevant service plan that is responsive to the individual's choices		
4. The individual's service plan was signed by a psychiatrist, ACT team leader and the client prior to the initiation of services		
5. Does the individual service plan contain the following elements:		
-A diagnosis of severe disabling mental illness (Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Psychotic Depression) by a licensed professional		
-Plans to address psychiatric conditions		
-Treatment goals & objectives (including target dates)		
-Preferred treatment approaches and related services		
-Educational, vocational, social, wellness management, residential or recreational goals, and concrete and measurable objectives		
-Psychopharmacological treatment plan		
-Crisis/relapse prevention plan including advance directive		
-An integrated substance abuse and mental health service plan for individuals with co-		

occurring disorders		
6. The individual service plan is reviewed and updated every six months	**Yes**	**No**
7. Do the progress notes reflect service interventions identified in the individual service plan as related to the following act services:		
Psychiatric Services		
Medication Management		
Counseling Services		
Psychotherapy		
Substance Abuse Treatment		
Housing Support		
Employment/Vocational Services		
Rehabilitation Services		
Case Management Services		
8. Do the progress notes and/or other relevant documentation reflect the billed modifier, level of interaction with the client and the service provider? Modifier activities must be indicated in the service plan. (*See below for modifiers)		
9. Do the progress notes and/or other relevant documentation reflect the number of units billed to Medicaid?		

***Modifier Activities:**
U1 = Face-to-face encounter with a client; encounters can occur outside the office (cell phone contacts and family or collateral contact cannot be billed as face-to-face encounters).
U2 = Collateral encounter occurred with members of the client's family or household, or with other contacts who interact with the client regularly and who are indentified in the service plan as having a role in the client's treatment.
U3 = Assertive outreach involving the ACT Team member monitoring the client's relationships within the community and early intervention if difficulty arises. The team must closely monitor relationships that the client has within the community.