Medicaid Billing Self-Assessment Worksheet (Assessment, Treatment Plan, Progress Notes)

Provider Name: _____

OASAS Provider #: _____

Service Type:	*Check One*
Part 822 Chemical Dependence Outpatient Clinic	____
Part 822.9 Chemical Dependence Outpatient Rehabilitation	____

Deficiency Rate Calculation		
Total Score:		
Sample Size:		
Deficiency Rate:	%	**(Total Score / Sample Size)**

Medicaid Recipient ID Number and Patient ID Number			*ADMISSION*				*TREATMENT PLAN*							*PROGRESS NOTES*								SCORE (0 or 1)
		1. Paid Service Date	2. Level of Care Determ Y/ N	3. Date of Admission	4. Evaluation Assessment Y / N	5. Admission Criteria Y / N	6. Individual Treatment Plan Y / N	7. Date of Treatment Plan	8. Within Required Time Y / N	9. Physician's Signature Y / N	10. Physician's Signature Date	11. Within Required Time Y / N	12. Treatment Plan Review Y/ N	13. Notes Exist for all Visits Y / N	14. Adequacy of Notes Y / N	15. Type of Visit A/I/G A/F/H	16. Sufficient Individual Visits Y / N	17. Group Session ≤ 15 patients	18. Duration Indicated Y/ N	19. Duration Adequate Y/ N	20. Treatment According to Plan Y/ N	
Medicaid ID:	XX12345X										Y											
Patient ID:	0123456789	07/13/03	Y	06/15/03	Y	Y	Y	07/03/03	Y	Y	07/03/03	Y	Y	Y	Y	G	Y	Y	Y	N	N	1
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Reviewer Name: _____ **Title:** _____ **Date:** _____

Medicaid Billing Self-Assessment Worksheet (Utilization Review)

Provider Name: _____

OASAS Provider #: _____

Service Type:	*Check One*
Part 822 Chemical Dependence Outpatient Clinic	☐
Part 822.9 Chemical Dependence Outpatient Rehabilitation	☐

Deficiency Rate Calculation (Individual Cases)		
Total Score:		
Sample Size:		
Deficiency Rate:	%	**(Total Score / Sample Size)**

DATA FOR INDIVIDUAL CASES

	Medicaid Recipient ID Number	Patient ID Number	Admission Date	Date of Initial UR Review was Performed on the 365th day after admission	Date of Subsequent Review was 90 Days after initial U/R	Score (0 or 1)
Sample	XX12345X	0123456789	**1/1/2007**	**1/1/2008**	**4/1/2008**	**0**
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Reviewer Name: _____ _____ **Date:** _____