Optum Public Sector San Diego

TREATMENT RECORD REVIEW TOOL

Provider Name:		**License Type:**		**Reviewer Name:**	
Date of Review:		**Audit Period From:**		**Audit Period To:**	
Type of Review:		**Client Number:**		**Client Initials:**	

Total Audit Score:		**Total Audit Questions:**		**Compliance Rate:**	

Administrative	
1. Each client has a separate record.	
2. Each client has emergency contact information.	
3. A consent to receive services has been signed by the client or legal representative. If under age 18, the consent is signed by the parent/guardian or Juvenile Court.	
4. **Medication Services only:** Consent for psychotropic medications has been signed by the provider and the client or legal representative. If under age 18, the consent is signed by the parent, guardian, or Juvenile Court.	
5. Notice of Privacy Practices has been provided as required by HIPAA.	
6. There is a written protocol for accommodating clients in a life threatening emergency.	
7. The provider makes arrangements for emergency coverage for all clients 24 hours per day/7 days per week. (Review how coverage is provided).	
8. Information is provided to clients which includes a description of services.	
9. Information is provided to clients which includes an explanation of the cancellation/no-show policy.	
10. Clients are informed they have the right to withdraw their consent at any time.	
11. Clients are provided with information regarding confidentiality protocols.	
12. There is documentation that reflects the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.	
13. There is documentation the client was provided an explanation of the Integrated Behavioral Health Member Handbook.	
14. There is documentation the client was provided the problem resolution process upon admission and annually.	
15. The record is clearly legible to someone other than the writer.	
16. If indicated, an authorization to release information has been signed and dated by the client or legal representative. If under age 18, the authorization is signed by the parent, guardian, or Juvenile Court. All required information has been completed.	
17. **Prescribers only:** There is documentation that the client was provided the Open Payments Database Notice.	
18. **Telehealth only:** There is documentation that reflects the risks or limitations related to receiving services through telehealth as compared to in person.	
19. **Telehealth only:** Consent indicates clients verbal or written acknowledgment.	

20. **Telehealth only:** An explanation that telehealth is voluntary and that consent can be withdrawn at any time.	
General Documentation Standards	
21. All entries (including but not limited to progress notes, assessments) in the record have the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed where appropriate.	
22. If the client has limited English proficiency, there is documentation that interpreter services were offered.	
23. If interpreter services were offered, there is documentation indicating whether the client accepted or declined the services.	
24. **Medication Services only:** Record includes a medication log with dosages of each medication, dates of initial prescription and refills.	
Initial Assessment	
25. The reasons for admission or initiation of treatment are indicated.	
26. A complete mental status exam is in the record, documenting the client's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.	
27. The behavioral health history includes an assessment of any abuse or trauma the client has experienced or if the client has been the perpetrator of abuse.	
28. A behavioral health history is included in the record.	
29. For clients 12 and older, a substance abuse screening occurs. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.	
30. For clients 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.	
31. If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.	
32. The behavioral health treatment history includes the following information: dates of previous treatment, providers of previous treatment, and therapeutic interventions and responses.	
33. A medical history including any current medical conditions is included in the record.	
34. Record includes current medications with the name of the prescriber.	
35. The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.	
36. **For children and adolescents:** A complete developmental history (physical, psychological, social, intellectual and academic) is documented.	
37. The behavioral health treatment history includes family history information.	
38. The record documents the cultural variables that may impact treatment.	
39. The record documents the presence or absence of relevant legal issues of the client and/or family.	
40. There is documentation that the client was asked about the community resources (support groups, social services, school based services, other social supports) they are currently utilizing.	
41. Initial assessment identifies client strengths. If the client is a child or adolescent, family strengths are included.	
42. The record documents a risk assessment appropriate to the level of care and population served which may include the presence or absence of suicidal or homicidal risk, danger toward self or others and/or high risk behaviors.	
43. The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	

44. The assessment documents a sexual history to include orientation and gender identity.	
45. The record documents a clearly substantiated ICD-10 diagnosis and an appropriate mental health Z-code (if applicable).	
46. The assessment has a clinical formulation which describes client's behavioral health needs (symptoms, condition, diagnosis and/or risk factors) and service recommendations including proposed plan of care to address the client's behavioral health needs.	
Problem List	
47. Problem list includes problems or illnesses identified beneficiary and/or their significant support person, as well as problems or diagnoses identified by a provider acting within their scope of practice.	
48. The name and title of the provider that identified, added, or removed the problem and the date the problem was identified, added or removed is included on the Problem List.	
49. The Problem List evidences that it has been updated on an ongoing basis to reflect the current presentation of the beneficiary and/or any relevant changes to the beneficiary's condition.	
Progress Notes	
50. All progress notes document the date of service.	
51. Progress notes document planned action steps and may include any update to the problem list as appropriate.	
52. All progress notes document the location of service.	
53. Progress notes document how the service addresses the client's behavioral health needs.	
54. Progress notes document recipient's response to the specialty mental health intervention(s).	
55. Progress notes document how services addressing physical health or substance use needs are integrated into the client's mental health treatment (education, resources, referrals, managing symptoms).	
56. All progress notes document the length of service rendered when providing a timed service.	
57. All progress notes document clearly who is in attendance during each session.	
58. All progress notes include documentation of the ICD 10 diagnosis for the session.	
59. All progress notes for group therapy are properly apportioned to all clients present.	
60. The progress notes reflect reassessments when clinically indicated.	
61. The progress notes reflect on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at-risk situations.	
62. Safety plan is created when active safety risks are identified.	
63. Safety plan is revisited after each crisis/SI/SA/HI/high-risk event.	
64. The progress notes document the date or timeframe of follow up appointments.	
65. The progress notes document when clients miss appointments and these services are not claimed.	
66. The progress notes document referrals made to other providers, agencies, and/or therapeutic services when indicated.	
67. Progress notes reflect discharge planning.	
Coordination of Care	
68. The record documents the client was asked whether he/she has a primary care physician (PCP). If applicable, includes PCP name and contact information.	

69. The record documents evidence of communication with PCP when clinically indicated (including but not limited to medication changes, medical conditions and/or change in diagnosis).	
70. The record documents the client was asked whether he/she is being seen by another behavioral health provider. If applicable, includes behavioral health provider name and contact information.	
71. The record documents evidence of communication with other behavioral health provider(s) when clinically indicated.	
Discharge and Transfer	
72. If the client was transferred/discharged to another provider or program, or system of care, there is documentation that communication/collaboration occurred (i.e transition tool, if applicable) with the receiving provider/program, or was attempted.	
73. Record documents a discharge summary, or appropriate follow-up efforts if the client terminated prematurely.	
74. The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.	
75. The discharge/aftercare/safety plan describes specific follow-up activities.	
76. Clinical records are completed within 30 days following discharge or last date of service.	