Optum Public Sector San Diego

TREATMENT RECORD REVIEW TOOL

Provider Name:

Date of Review:

Reviewer Name:

Audit Period:

Client Initials:

Client Number:

Compliance Rate:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
General Documentation Standards				
1	Each client has a separate record.			
2	Each record includes the client's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
3	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed where appropriate.			
4	The record is clearly legible to someone other than the writer.			
5	There is documentation that the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.			
6	There is documentation that reflects the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			
7	There is documentation that the client was provided an explanation of the State Guide to Medi-Cal Behavioral Health Services and the grievance/appeal process upon admission and annually.			
8	If the client has limited English proficiency, there is documentation that interpreter services were offered.			
9	If interpreter services were offered, there is documentation indicating whether the client accepted or declined the services.			
Initial Assessment				
10	The reasons for admission or initiation of treatment are indicated.			
11	A complete clinical case formulation is documented in the record (e.g. primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments)			
12	A Title 9 Medi-Cal included primary treatment diagnosis is present in the record and consistent with assessment data.			

13	A behavioral health history is included in the record.			
14	A medical history and/or physical exam (appropriate to the level of care) is included in the record.			
15	Was a current medical condition identified? **This is a non-scored question.**			
16	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical provider occurred. **This is a non-scored question.**			
17	If a medical condition was identified, there is documentation that the client/guardian refused consent for the release of information to the treating medical provider. **This is a non-scored question.**			
18	Medical history includes medications prescribed to the client.			
19	Medication history includes dosages of each medication, dates of initial prescriptions and refills are documented. **(For Medication Services only)**			
20	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
21	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.			
22	The behavioral health treatment history includes the following information: dates of previous treatment, providers of previous treatment, and therapeutic interventions and responses.			
23	The medical treatment history includes the following information: known medical conditions, dates of treatment, providers of previous treatment, current treating providers, and current interventions and responses.			
24	Initial assessment identifies both client and family strengths.			
25	The behavioral health treatment history includes family history information.			
26	The medical treatment history includes family history information.			
27	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 and danger toward self or others.			
28	The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.			
29	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.			
30	**For adolescents**: The assessment documents a sexual behavior history.			

31	**For children and adolescents**: a complete developmental history (physical, psychological, social, intellectual and academic) is documented.			
32	The record documents the cultural variables that may impact treatment.			
33	The record documents the presence or absence of relevant legal issues of the client and/or family.			
34	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.			
35	There is evidence that the assessment is used in developing the treatment plan and goals.			
36	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.			
37	For clients 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.			
38	If the screening indicates an **active** alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
39	The substance identified as being misused was alcohol. **This is a non-scored question.**			
40	The substance(s) identified as being misused were substance(s) other than alcohol. **This is a non-scored question.**			
41	The substance(s) identified as being misused were alcohol and other substance(s). **This is a non-scored question.**			
Treatment Planning				
42	An initial treatment plan is established at each level of care with goals, treatment priorities, and milestones for progress is in the record.			
43	The treatment plan is consistent with the diagnosis.			
44	There is documentation (a signed form or in progress note) that the client or legal guardian (based on age of consent) has agreed to the treatment plan within 30 days of initial assessment and updated at each authorization request.			
45	The treatment plan includes objective and measurable short and long term goals.			
46	The treatment plan goals identify the proposed type(s) of intervention.			
47	The treatment plan has estimated time frames for goal attainment.			
48	The treatment plan includes a safety plan when active risk issues are identified.			

49	The treatment plan is updated whenever goals are achieved or new problems are identified.			
50	The treatment plan is reviewed and updated with the client at regular intervals.			
51	When applicable, the treatment record**, including the treatment plan,** reflects discharge planning.			
52	The treatment record documents and addresses biopsychosocial needs.			
53	The treatment record indicates the client's involvement in care and service.			
54	When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.			
Progress Notes				
55	All progress notes document the length of service rendered when providing a timed service.			
56	All progress notes document the date of service rendered.			
57	All progress notes document clearly who is in attendance during each session.			
58	All progress notes include documentation of the 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	The progress notes document billable services according to Title 9 requirements.			
63	The progress notes describe progress or lack of progress towards treatment plan goals.			
64	The progress notes document the dates of follow up appointments.			
65	The progress notes document when clients miss appointments and these services are not claimed.			
66	The progress notes document any referrals made to other providers, agencies, and/or therapeutic services when indicated.			
67	If an Outpatient Authorization Request (OAR) was completed for continued authorization, progress notes document all concerns identified.			

68	The progress notes document medical necessity in all relevant aspects of client care.			
Coordination of Care				
69	Does the client have a medical physician (Primary Care Physician/PCP)? **This is a non-scored question.**			
70	The record documents that the client was asked whether they have a PCP. **Y or N Only**			
71	If the client has a PCP there is documentation that communication/collaboration occurred.			
72	If the client has a PCP, there is documentation that the client/guardian refused consent for the release of information to the PCP.			
73	Is the client being seen by another behavioral health provider (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
74	The record documents that the client was asked whether they are being seen by another behavioral health provider. **Y or N Only**			
75	If the client is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.			
76	If the client is being seen by another behavioral health provider, there is documentation that the client/guardian refused consent for the release of information to the behavioral health provider.			
Discharge and Transfer				
77	Was the client transferred/discharged to another provider or program? **This is a non-scored question.**			
78	If the client was transferred/discharged to another provider or program, there is documentation that communication/collaboration occurred with the receiving provider/program.			
79	If the client was transferred/discharged to another provider or program, there is documentation that the client/guardian refused consent for release of information to the receiving provider/program.			
80	Prompt referrals to the appropriate level of care are documented when clients cannot be safely treated at their current level of care secondary to homicidal or suicidal risk or an inability to conduct activities of daily living.			
81	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
82	The discharge/aftercare/safety plan describes specific follow up activities.			
83	Clinical records are completed within 30 days following discharge.			

Administrative				
84	A consent to receive services has been signed by client or if under age 18 by the parent/guardian or Juvenile Court.			
85	If indicated, an authorization to release information has been signed and dated by client or if under age 18 by the parent, guardian, or Juvenile Court, if applicable, and all required information has been completed.			
86	**For Medication Services only**: Consent for psychotropic medications has been signed by physician and client or if under age 18 by the parent/guardian or Juvenile Court.			
87	Notice of Privacy Practices has been provided as required by HIPAA			