Michigan Engagement Center - Provider Treatment Record Audit Tool

Provider Name_____ **Date of Audit**_____ **Time:**_____

Provider Address/Location_____ **Auditor Initials**_____

Provider City_____ **State/Zip**_____ **Total Records Audited**_____

Contact Name_____ **Phone:**_____ **Page 1**

Reason for Review: Routine TRR ☐ **Quality Review** ☐ **Action Plan Follow-Up** ☐

Rec #	Member Name	Member DOB	Member Contract	Client Company	Primary Dx Code	Secondary Dx Code
1						
2						
3						
4						
5						
6						
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8						
9						
10						
11						
12						

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Provider Address/Location_____	**Auditor Initials**_____
Provider City_____ **State/Zip**_____	**Total Records Audited**_____
Contact Name_____ **Phone:**_____	**Page 2**

Reason for Review: Routine TRR ☐ **Quality Review** ☐ **Action Plan Follow-Up** ☐

Rec #	Member Name	Member DOB	Member Contract	Client Company	Primary Dx Code	Secondary Dx Code
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						

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Provider Name_____ **Date of Review**_____

Provider Location_____ **Auditor Initials**_____

******NOTE: Shaded boxes allow only a YES or NO scoring option.******

	Record #	1	2	3	4	5	6	7	8	9	10	11	12
	Section A: Record Organization (.05)												
1	Each page contains the member name or ID number												
2	The member's home address is documented												
3	The member's employer or school is documented												
4	The member's home/cell telephone number is documented												
5	The member's work telephone number is documented												
6	Marital/legal status is noted.												
7	Emergency contacts are documented in the record												
8	All entries are dated and signed by practitioner including professional degree.												
9	The record is legible to someone other than the writer.												
	Section B: Consent Forms (.05)												
1	There is a consent for treatment form signed.												
2	Medication informed consent form is signed if applicable.												

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	Record #	1	2	3	4	5	6	7	8	9	10	11	12
	Section C: Clinical Assessment (.25)												
1	Presenting problem: includes relevant psychological and social conditions affecting medical and psychiatric status												
2	MSE: documents affect, speech, mood, thought content, judgment, insight, attention, concentration, memory and impulse control												
3	Risk assessment completed												
4	Allergies and adverse reactions clearly documented or the lack of known allergies and sensitivities to pharmaceuticals or other substances noted (NKA)												
5	For children and adolescents, perinatal and prenatal events, a developmental and educational hx are documented												
6	For children and adolescents: The record reflects active involvement of family/primary caretakers in assessment/treatment unless contraindicated												
7	For children and adolescents, there is documentation of school functioning assessment												
8	Relevant medical history and conditions are assessed and noted, including the impact on behavioral/emotional functioning.												
9	Medication history & outcome, dates of initial prescription, labs as appropriate												
10	A complete psychiatric treatment history is documented												
11	For members 12 and older - documentation of past and present use of ETOH												
12	For members 12 and older - documentation of past and present use of illicit, prescribed and OTC drugs												
13	For members 12 and older - documentation of past and present use of tobacco												

	Record #	1	2	3	4	5	6	7	8	9	10	11	12
14	The DSM-IV/ICD-9 diagnosis is consistent with presenting problems, history, mental status exam, and/or other assessment data is documented in the treatment record												
	Section D: Treatment Plan (.20)												
1	There is an individualized treatment plan that is consistent with the diagnosis and the member's treatment needs.												
2	The treatment plan identifies ways to measure goal attainments												
3	The treatment plan has estimated timeframes or target dates for goal attainment or resolution.												
4	Treatment interventions consistent with treatment goals												
5	There is evidence of member involvement/understanding of the treatment plan												
6	The record indicates evidence of coordination with the youth's school to achieve related treatment goals. (if applicable)												
	Section E: Coordination of Care (.20)												
1	There is evidence in the record that the member has no PCP or other healthcare provider.												
2	There is evidence of a signed ROI for coordination of care with the PCP.												
3	There is evidence in the record that the member refused to consent to coordination with medical care.												
4	If the member declined, there is evidence that the member was given VO COC member tip sheet. (Score n/a if member consented or no declination found)												
5	If the member signed a ROI, there is evidence that the coordination of care took place .												

	Record #	1	2	3	4	5	6	7	8	9	10	11	12
6	(For INPATIENT records only) There is evidence of coordination of care with consultants, ancillary providers and/or other behavioral healthcare institutions.												
7	For members receiving psychotropic medications there is evidence of coordination with primary care												
8	(For OUTPATIENT records only) The treatment record shows evidence of coordination of care with other outpatient behavioral healthcare providers (BHP).												
	Section F: Progress Notes (.10)												
1	Risk assessment is complete.												
2	Ongoing problem/impairments are noted												
3	The interventions/strategies used in treatment sessions are documented												
4	The interventions are consistent with the treatment plan												
5	Strengths and limitations in achieving treatment plan goals are documented												
6	The dates of follow-up appointments are documented												
7	The discharge plan is present at discharge												
	Section G: Referrals (.05)												
1	Prompt referral to the appropriate level of care for member's who become suicidal, homicidal or unable to conduct ADLs												
2	Record reflects referral to appropriate preventive services, community resources and other suitable ancillary referrals including referrals to psychiatrist or therapists												

	Record #	1	2	3	4	5	6	7	8	9	10	11	12
	Section H: Cultural Competency (.05)												
1	There is evidence that clinical assessment is culturally relevant (i.e.; addresses issues relevant to individual's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.)												
2	There is evidence that treatment plan is culturally relevant												
3	There is evidence of appropriate use of interpreters, if applicable												
	Section I: Medication Management (Prescribers Only) (.05)												
1	Progress note includes documentation of current medication, dosage and dates of dosage changes												
2	There is documentation of the education of women of child bearing age of the need to notify the psychiatrist immediately if pregnancy occurs.												
	Section J: Use of Screening Tools (Not Scored)												
1	**Use of Alcohol Screening Tools**	***Score "Y" if present otherwise leave blank***											
	Alcohol Use Disorders Identification Test (AUDIT) or AUDIT-C												
	NIAA Two Question Screen												
	MAST/BMAST												
	CAGE												
	DSM/ICD-9												
	Other Tool Was Used												
	No screening tool was used												

	Record #	1	2	3	4	5	6	7	8	9	10	11	12
2	**Use of Depression Screening Tools**	***Score "Y" if present otherwise leave blank***											
	PHQ-9/PRIME MD												
	Beck Depression Inventory												
	Zung												
	HAM-D												
	CES-D												
	Two-Question Screen (Whooley)												
	DSM/ICD-9												
	Other Tool Was Used												
	No screening tool was used												
	Attention-Deficit / Hyperactivity Disorder ***Codes:* 314.00, 314.01, 314.9**	**Clinical Practice Guidlelines Adherence**											
	Record #	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
1	Is there demonstrated evidence of impairment in at least two areas (social, academic or occupation) of functioning												
2	Record reflects active involvement of family/primary caretakers in the assessment and treatment of patient unless contraindicated												
3	Co-morbid problems are assessed upon initial evaluation and at least annually												
4	Record reflects education about ADHD and parent training in behavioral management												
5	When medication is prescribed there is evidence of consistency among the signs and symptoms, diagnosis, and medications prescribed												
6	When medication is prescribed there is evidence of an evaluation of the patient's response to medication and adjustments as needed.												

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	Record #	1	2	3	4	5	6	7	8	9	10	11	12
	Bipolar Disorder **Codes: 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89**	**Clinical Practice Guidlelines Adherence**											
1	Mood symptoms and suicidality are assessed at every visit												
2	Co-morbid problems are assessed upon initial evaluation and at least annually												
3	When medications are prescribed that require serum level monitoring and/or laboratory tests to screen for medication side effects, those tests are conducted as recommended by the drug manufacturer												
	Major Depressive Disorder **296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36**	**Clinical Practice Guidlelines Adherence**											
1	Mood symptoms and suicidality are assessed at every visit												
2	Co-morbid problems are assessed upon initial evaluation and at least annually												
3	When medication is prescribed there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g.; MSW, PhD)												

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	Record #	1	2	3	4	5	6	7	8	9	10	11	12
	Schizophrenia **295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90**	**Clinical Practice Guidlelines Adherence**											
1	There is evidence of an assessment of positive signs of psychosis, e.g.; delusions and/or hallucinations												
2	Co-morbid problems are assessed upon initial evaluation and at least annually												
3	When medication is prescribed there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g.; MSW, PhD)												
4	When anti-psychotic medications are prescribed, there is evidence of observation for side effects including EPS such as dystonic reactions, akathisia (can't sit still) or akinesia. (Note this applies to all discipline levels; NA may not be checked.)												

	Record #	1	2	3	4	5	6	7	8	9	10	11	12
	Co-Occurring Psychiatric and Substance Related Disorders	**Clinical Practice Guidlelines Adherence**											

This guideline covers co-occurring psychiatric and substance use disorders concentrating on the combinations of disorders from list 1 and list 2 below:

List 1 - Psychiatric Codes

295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 296.40, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89, 296.90, 298.9, 311

List 2 - Substance Related Codes

292.0, 292.11, 292.12, 292.81, 292.82, 292.83, 292.84, 292.89, 292.9, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 304.90, 305.00, 305.10, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90

	Record #	1	2	3	4	5	6	7	8	9	10	11	12
1	Substance abuse history and usage patterns are fully documented (includes first use to present)												
2	Treatment plan includes identification of barriers to adherence and interventions that address those barriers												
3	Treatment plan includes relapse plan, including identification of relapse triggers, skills needed to deal with triggers, and contingency plan for difficult instances												
4	Treatment plan includes both SA and psychiatric issues and interventions												

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Provider Name_____ **Date of Review**_____

Provider Location_____ **Auditor Initials**_____

******NOTE: Shaded boxes allow only a YES or NO scoring option.******

	Record #	13	14	15	16	17	18	19	20	21	22	23	24
	Section A: Record Organization (.05)												
1	Each page contains the member name or ID number												
2	The member's home address is documented												
3	The member's employer or school is documented												
4	The member's home/cell telephone number is documented												
5	The member's work telephone number is documented												
6	Marital/legal status is noted.												
7	Emergency contacts are documented in the record												
8	All entries are dated and signed by practitioner including professional degree.												
9	The record is legible to someone other than the writer.												
	Section B: Consent Forms (.05)												
1	There is a consent for treatment form signed.												
2	Medication informed consent form is signed if applicable.												

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	Record #	13	14	15	16	17	18	19	20	21	22	23	24
	Section C: Clinical Assessment (.25)												
1	Presenting problem: includes relevant psychological and social conditions affecting medical and psychiatric status												
2	MSE: documents affect, speech, mood, thought content, judgment, insight, attention, concentration, memory and impulse control												
3	Risk assessment completed												
4	Allergies and adverse reactions clearly documented or the lack of known allergies and sensitivities to pharmaceuticals or other substances noted (NKA)												
5	For children and adolescents, perinatal and prenatal events, a developmental and educational hx are documented												
6	For children and adolescents: The record reflects active involvement of family/primary caretakers in assessment/treatment unless contraindicated												
7	For children and adolescents, there is documentation of school functioning assessment												
8	Relevant medical history and conditions are assessed and noted, including the impact on behavioral/emotional functioning.												
9	Medication history & outcome, dates of initial prescription, labs as appropriate												
10	A complete psychiatric treatment history is documented												
11	For members 12 and older - documentation of past and present use of ETOH												
12	For members 12 and older - documentation of past and present use of illicit, prescribed and OTC drugs												
13	For members 12 and older - documentation of past and present use of tobacco												

	Record #	13	14	15	16	17	18	19	20	21	22	23	24
14	The DSM-IV/ICD-9 diagnosis is consistent with presenting problems, history, mental status exam, and/or other assessment data is documented in the treatment record												
	Section D: Treatment Plan (.20)												
1	There is an individualized treatment plan that is consistent with the diagnosis and the member's treatment needs.												
2	The treatment plan identifies ways to measure goal attainments												
3	The treatment plan has estimated timeframes or target dates for goal attainment or resolution.												
4	Treatment interventions consistent with treatment goals												
5	There is evidence of member involvement/understanding of the treatment plan												
6	The record indicates evidence of coordination with the youth's school to achieve related treatment goals. (if applicable)												
	Section E: Coordination of Care (.20)												
1	There is evidence in the record that the member has no PCP or other healthcare provider.												
2	There is evidence of a signed ROI for coordination of care with the PCP.												
3	There is evidence in the record that the member refused to consent to coordination with medical care.												
4	If the member declined, there is evidence that the member was given VO COC member tip sheet. (Score n/a if member consented or no declination found)												
5	If the member signed a ROI, there is evidence that the coordination of care took place .												

	Record #	13	14	15	16	17	18	19	20	21	22	23	24
6	(For INPATIENT records only) There is evidence of coordination of care with consultants, ancillary providers and/or other behavioral healthcare institutions.												
7	For members receiving psychotropic medications there is evidence of coordination with primary care												
8	(For OUTPATIENT records only) The treatment record shows evidence of coordination of care with other outpatient behavioral healthcare providers (BHP).												
	Section F: Progress Notes (.10)												
1	Risk assessment is complete.												
2	Ongoing problem/impairments are noted												
3	The interventions/strategies used in treatment sessions are documented												
4	The interventions are consistent with the treatment plan												
5	Strengths and limitations in achieving treatment plan goals are documented												
6	The dates of follow-up appointments are documented												
7	The discharge plan is present at discharge												
	Section G: Referrals (.05)												
1	Prompt referral to the appropriate level of care for member's who become suicidal, homicidal or unable to conduct ADLs												
2	Record reflects referral to appropriate preventive services, community resources and other suitable ancillary referrals including referrals to psychiatrist or therapists												

	Record #	13	14	15	16	17	18	19	20	21	22	23	24
	Section H: Cultural Competency (.05)												
1	There is evidence that clinical assessment is culturally relevant (i.e.; addresses issues relevant to individual's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.)												
2	There is evidence that treatment plan is culturally relevant												
3	There is evidence of appropriate use of interpreters, if applicable												
	Section I: Medication Management (Prescribers Only) (.05)												
1	Progress note includes documentation of current medication, dosage and dates of dosage changes												
2	There is documentation of the education of women of child bearing age of the need to notify the psychiatrist immediately if pregnancy occurs												
	Section J: Use of Screening Tools (Not Scored)												
1	**Use of Alcohol Screening Tools**	***Score "Y" if present otherwise leave blank***											
	Alcohol Use Disorders Identification Test (AUDIT) or AUDIT-C												
	NIAA Two Question Screen												
	MAST/BMAST												
	CAGE												
	DSM/ICD-9												
	Other Tool Was Used												
	No screening tool was used												

	Record #	13	14	15	16	17	18	19	20	21	22	23	24
2	**Use of Depression Screening Tools**	***Score "Y" if present otherwise leave blank***											
	PHQ-9/PRIME MD												
	Beck Depression Inventory												
	Zung												
	HAM-D												
	CES-D												
	Two-Question Screen (Whooley)												
	DSM/ICD-9												
	Other Tool Was Used												
	No screening tool was used												
	Attention-Deficit / Hyperactivity Disorder ***Codes:* 314.00, 314.01, 314.9**	**Clinical Practice Guidlelines Adherence**											
	Record #	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
1	Is there demonstrated evidence of impairment in at least two areas (social, academic or occupation) of functioning												
2	Record reflects active involvement of family/primary caretakers in the assessment and treatment of patient unless contraindicated												
3	Co-morbid problems are assessed upon initial evaluation and at least annually												
4	Record reflects education about ADHD and parent training in behavioral management												
5	When medication is prescribed there is evidence of consistency among the signs and symptoms, diagnosis, and medications prescribed												
6	When medication is prescribed there is evidence of an evaluation of the patient's response to medication and adjustments as needed.												

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	Record #	13	14	15	16	17	18	19	20	21	22	23	24
	Bipolar Disorder ***Codes:* 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89**	**Clinical Practice Guidlelines Adherence**											
1	Mood symptoms and suicidality are assessed at every visit												
2	Co-morbid problems are assessed upon initial evaluation and at least annually												
3	When medications are prescribed that require serum level monitoring and/or laboratory tests to screen for medication side effects, those tests are conducted as recommended by the drug manufacturer												
	Major Depressive Disorder **296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36**	**Clinical Practice Guidlelines Adherence**											
1	Mood symptoms and suicidality are assessed at every visit												
2	Co-morbid problems are assessed upon initial evaluation and at least annually												
3	When medication is prescribed there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g.; MSW, PhD)												

ValueOptions - Michigan Engagement Center --- Treatment Record Documentation Audit Tool

	Record #	13	14	15	16	17	18	19	20	21	22	23	24
	Schizophrenia **295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90**	**Clinical Practice Guidlelines Adherence**											
1	There is evidence of an assessment of positive signs of psychosis, e.g.; delusions and/or hallucinations												
2	Co-morbid problems are assessed upon initial evaluation and at least annually												
3	When medication is prescribed there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g.; MSW, PhD)												
4	When anti-psychotic medications are prescribed, there is evidence of observation for side effects including EPS such as dystonic reactions, akathisia (can't sit still) or akinesia. (Note this applies to all discipline levels; NA may not be checked.)												

Record #	13	14	15	16	17	18	19	20	21	22	23	24
Co-Occurring Psychiatric and Substance Related Disorders	**Clinical Practice Guidlelines Adherence**											

This guideline covers co-occurring psychiatric and substance use disorders concentrating on the combinations of disorders from list 1 and list 2 below:

List 1 - Psychiatric Codes

295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 296.40, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52,

List 2 - Substance Related Codes

292.0, 292.11, 292.12, 292.81, 292.82, 292.83, 292.84, 292.89, 292.9, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 304.90, 305.00, 305.10, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90

	Record #	1	2	3	4	5	6	7	8	9	10	11	12
1	Substance abuse history and usage patterns are fully documented (includes first use to present)												
2	Treatment plan includes identification of barriers to adherence and interventions that address those barriers												
3	Treatment plan includes relapse plan, including identification of relapse triggers, skills needed to deal with triggers, and contingency plan for difficult instances												
4	Treatment plan includes both SA and psychiatric issues and interventions												

Data Definitions for the Provider Treatment Record Audit Tool

	Standard	Scoring Options	To Score Yes, the Record Must Contain
	Section A: Record Organization (.05)		
1	Each page contains member name or ID number	Y, N	The member name or identification number is recorded on each and every page of the treatment record
2	The member's home address is documented	Y, N	The member's home address is present in the record
3	The member's employer or school is documented	Y, N, N/A	The member's employer is recorded. If a child, the school is recorded
4	The member's home/cell telephone number is documented	Y, N	The member's home/cell telephone number is recorded
5	The member's work telephone number is documented	Y, N, N/A	The member's work telephone number is recorded
6	Marital/legal status is noted.	Y, N, N/A	All relevant elements must be present. For children, marital status is irrelevant.
7	Emergency contacts are documented in the record	Y, N	The names and phone numbers of whom to contact in case of an emergency is present in the record
8	All entries are dated and signed by practitioner including professional degree.	Y, N	The day, month and year is recorded for each entry. A minimum of first initial, last name and degree appears after each entry. If a signature is stamped, score "No." If records are electronic, a unique electronic identifier is acceptable.
9	The record is legible to someone other than the writer.	Y, N	An entry that a reasonable person can read at a normal pace, i.e. the auditor does not have to spend time trying to decipher individual words or phrases.
	Section B: Disclosure Forms (.05)		
1	There is a consent for treatment form signed.	Y, N	There is evidence in the record of a signed consent for treatment. If a minor is being treated there is evidence of parental/legal guardian consent.
2	There is a medication informed consent form signed. (applies to prescribing providers only)	Y, N, N/A	There is a note in the record to indicate that the medication and side effects were reviewed with the member. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber.
	Section C: Clinical Assessment (.25)		
1	Presenting problem: includes relevant psychological and social conditions affecting medical and psychiatric status	Y, N	Presenting problems (current symptoms, history of symptoms, problem behaviors and relevant psychological conditions affecting the member's medical and psychiatric status) are documented in the assessment and addressed in the treatment plan. A family history in which the presence or absence of psychiatric and/or substance abuse history among family members (up to the 2nd degree) is noted.
2	MSE: documents affect, speech, mood, thought content, judgment, insight, attention, concentration, memory and impulse control	Y, N	All elements are documented in the initial assessment. Updates/changes are documented in the progress notes.

Data Definitions for the Provider Treatment Record Audit Tool

	Standard	Scoring Options	To Score Yes, the Record Must Contain
3	A risk assessment is completed.	Y, N	There is evidence that the member was thoroughly evaluated at intake for any risk of dangerousness to self/others or any inability to conduct activities of daily living. For those members identified as being at risk, it is prominently noted in the record
4	Allergies and adverse medication reactions clearly are documented or the lack of known allergies and sensitivities to pharmaceuticals or other substances noted (NKA)	Y, N, N/A	Documentation of allergies or adverse reactions to pharmaceuticals and other substances are documented upon initial assessment. N/A is scored if medication is not prescribed or the practitioner being reviewed is not a prescriber.
5	For children and adolescents, perinatal and prenatal events and educational hx are documented	Y, N, N/A	All elements of the developmental history including physical, psychological, social, intellectual and academic must be present. N/A only if the member is 18 or over.
6	For children and adolescents: the record reflects active involvement of family/primary caretakers in assessment/treatment unless contraindicated	Y, N, N/A	Family involvement is documented unless contraindicated. Look for parent/guardian signatures on the treatment plan and/or documentation of family involvement in the progress notes. N/A only if the member is age 18 and above.
7	For children and adolescents: there is documentation of an assessment of school functioning	Y, N, N/A	There is a description or note regarding the member's academic and behavioral functioning. N/A if member is age 18 or over.
8	Relevant medical history and conditions are assessed and noted, including the impact on behavioral/emotional functioning	Y, N, N/A	Medical conditions receiving treatment are listed in the assessment. The status of any medical condition(s) while the member is receiving behavioral health services is documented and updated, as necessary, in the record
9	Medication history & outcome, dates of initial prescription, labs as appropriate	Y, N. N/A	For Prescribers: all elements must be documented. Medication prescribed, dosages of each and dates of initial prescription and refills. There is documentation of lab work as appropriate. For Non-Prescribing Practitioners: the treatment record indicates what medications have been prescribed and the name of the prescriber. N/A is scored if medications are not being prescribed.
10	A complete psychiatric treatment history is documented	Y, N. N/A	Documentation includes previous treatment dates, provider identification, therapeutic interventions and responses. N/A is scored if there is documentation that there is no prior history of psychiatric treatment.
11	For members 12 and older - documentation of past and present use of ETOH	Y, N. N/A	N/A is scored only if the member is under the age of 12.
12	For members 12 and older - documentation of past and present use of illicit, prescribed and OTC drugs	Y, N. N/A	N/A is scored only if the member is under the age of 12.
13	For members 12 and older - documentation of past and present use of tobacco	Y, N. N/A	N/A is scored only if the member is under the age of 12.
14	The DSM-IV/ICD-9 diagnosis is consistent with presenting problems, history, mental status exam, and/or other assessment data is documented in the treatment record	Y, N	Data that supports and is consistent with the documented diagnosis. All five Axes must be present.

Data Definitions for the Provider Treatment Record Audit Tool

	Standard	Scoring Options	To Score Yes, the Record Must Contain
	Section D: Treatment Plan (.20)		
1	There is an individualized treatment plan that is consistent with the diagnosis and the member's treatment needs.	Y, N	There is a treatment plan in the record that is consistent with the member's assessment and individualized to the member's needs.
2	The treatment plan identifies ways to measure goal attainments	Y, N	
3	The treatment plan has estimated timeframes or target dates for goal attainment or resolution.	Y, N	
4	Treatment interventions are consistent with treatment goals	Y, N, N/A	Documentation that the interventions provided fit with the treatment plan goals. SCORE N/A IF TWO VISITS OR LESS.
5	There is evidence of member involvement/understanding of plan	Y, N	
6	The record indicates evidence of coordination with the youth's school to achieve related treatment goals. (if applicable)	Y, N, N/A	
	Section E: Coordination of Care (.20)		
1	There is evidence in the record that the member has no PCP or other healthcare provider		
2	There is evidence of a signed ROI for coordination of care with the PCP.	Y. N. N/A	The record should contain a signed release of information form. Score N/A if the member declined coordination or the member does not have an identified PCP.
3	There is evidence in the record that the member refused to consent to coordination with medical care	Y, N, N/A	A declination for coordination must be signed by the member. A notation by clinic staff of member refusal is scored as "no" evidence. Score N/A if the member consented to coordination or does not have an identified PCP.
4	If the member declined, there is evidence that the member was given VO COC member tip sheet. (Score n/a if member consented or no declination found)	Y, N, N/A	The record notes that the member was given the VO COC information sheet or other clinic COC educational material. Score N/A if member consented to coordination, no signed declination found in the record or the member does not have an identified PCP)
5	If the member signed a ROI, there is evidence that the coordination of care took place	Y, N. N/A	Evidence of coordination includes a copy of a dated letter to the PCP, a copy of a successful fax transmission, or an initialed and dated notation at the bottom of the signed release form indicating how (fax/mail) and when (date) the coordination took place. Other documentation that is evidence of coordination is acceptable.
6	(For INPATIENT records only), There is evidence of coordination of care with consultants, ancillary providers and/or other health care institutions.	Y, N, N/A	Score N/A if record under review is out-patient treatment.
7	For members receiving psychotropic medications there is evidence of coordination with primary care	Y, N. N/A	There record documentation reflects that the member is being prescribed medication(s) by the provider under review AND there is documentation that coordination of care with medical healthcare has occurred. This includes PCPs or other medical healthcare

	Standard	Scoring Options	To Score Yes, the Record Must Contain
8	(For OUTPATIENT records only) The treatment record shows evidence of coordination of care with other outpatient behavioral healthcare providers .	Y, N, N/A	There is evidence of communication with other OP providers. N/A is scored when there is no other behavioral healthcare provider.

Data Definitions for the Provider Treatment Record Audit Tool

	Standard	Scoring Options	To Score Yes, the Record Must Contain
	Section F: Progress Notes (.10)		
1	Risk assessment complete	Y, N, N/A	Practitioner assess the member's mood at every visit. Risk is assessed as appropriate.
2	Ongoing problem/impairments noted	Y, N	
3	The interventions/strategies used in sessions are documented	Y, N	
4	The interventions are consistent with the treatment plan	Y, N	
5	The strengths and limitations in achieving treatment plan goals are documented	Y, N	There is documentation that movement or lack thereof toward treatment goals is related to member strengths and/or limitations.
6	The dates of follow-up appointments are documented	Y, N, N/A	N/A is scored if it is documented that the member is not expected to continue or return to treatment.
7	The discharge plan is present at discharge	Y, N, NA	
	Section G: Referrals (.05)		
1	Prompt referral to the appropriate level of care for members who become suicidal, homicidal, or unable to conduct ADLs	Y, N. N/A	N/A is scored if the member is not homicidal, suicidal or able to conduct activities of daily living
2	Record reflects referral to appropriate preventive services, community resources and other suitable ancillary referrals including referrals to psychiatrist or therapists	Y, N. N/A	Documentation of the clinician's efforts to educate the member about approaches that might augment the treatment being provided: relapse prevention, stress management, wellness programs, lifestyle changes, AA/NA and other referrals/community based help.
	Section H: Cultural Competency (.05)		
1	There is evidence that clinical assessment is culturally relevant	Y, N	The practitioner incorporates into the clinical assessment relevant issues including the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, etc.
2	There is evidence that treatment plan is culturally relevant	Y, N	The practitioner incorporates into the treatment plan relevant issues including the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, etc.
3	There is evidence of appropriate use of interpreters, if applicable	Y, N, NA	
	Section I: Medication Management (Prescribers only) (.05)		
1	Progress note includes documentation of current medication, dosage, dates of dosage changes	Y, N, N/A	
2	There is documentation of the education of women of child bearing age of the need to notify the psychiatrist immediately if pregnancy occurs	Y, N, N/A	