Clinical Treatment Record Review
Audit Tool

Provider Name: _____ Discipline: _____

Practice Name: _____ Solo ☐ Group ☐

_____

Provider ID Number:_____

Provider Location: _____

Address: _____ Suite: _____

City: State: Zip:

_____ _____ _____

Phone Number: _____ Fax Number: _____

Enrollee ID: Age:

_____ _____

Diagnosis Code Primary:_____ Secondary:_____

Office Contact Name: _____

Verbal Summary of Treatment Record Audit Results Given To: _____

Was Compliance with Clinical Practice Guidelines Discussed? (check one): Yes ☐ No ☐

Reason for Review (please check one): Quality Review ☐ Action Plan Follow-up ☐ Routine Clinical Record Review ☐ Recredentialing ☐

Other ☐

Affected Account(s) _____ _____ _____ _____

Standard	Yes	No	N/A	Comments
1. Each page in the treatment record contains the enrollee's name or ID number.				
2. Each treatment record includes the enrollee's address, employer or school name, home telephone number, work telephone number, emergency contacts, marital status or legal status, appropriate consent forms, and guardianship information if relevant.				
3. All entries in the treatment record include the responsible clinician's name, professional degree, and relevant identification number, if applicable.				
4. All entries in the treatment record are dated.				
5. The treatment record is legible to someone other than the writer. (A second surveyor examines any record judged to be illegible by one clinical surveyor)				
6. Relevant medical conditions are listed, prominently identified, and revised as appropriate in the treatment record.				
7. Presenting problems, along with relevant psychological and social conditions affecting the enrollee's medical and psychiatric status, are documented in the treatment record.				
8. Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented and revised in the treatment record in compliance with *ValueOptions'* written protocols.				
9. Allergies, adverse reactions or no known allergies are clearly documented in the treatment record.				
10. A medical and psychiatric history is documented in the treatment record, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.				
11. For enrollees 12 and older, documentation in the treatment record includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs. N/A if the enrollee is under the age of twelve.				
12. A mental status evaluation that includes the enrollee's affect, speech, mood, thought content, judgment, insight, attention, concentration, memory and impulse control is documented in the treatment record.				
13. A DSM-IV/ICD9 diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data is documented in the treatment record.				

Standard	Yes	No	N/A	Comments
14. Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated time frames for goal attainment or problem resolution.				
15. The focus of treatment interventions is consistent with the treatment plan goals and objectives.				
16. Each treatment record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills. For non-prescribing practitioners, each treatment record indicates what medications have been prescribed and the name of the prescriber. N/A is scored if medications are not prescribed.				
17. Informed consent for medication and the enrollee's level of understanding is documented. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g., MSW, PhD)				
18. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A is scored if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g. MSW, PhD)				
19. Progress notes describe enrollee strengths and limitations in achieving treatment plan goals and objectives.				
20. Enrollees who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care. N/A is scored if the enrollee is not homicidal, suicidal, or unable to conduct activities of daily living.				
21. The treatment record documents preventive services, as appropriate (e.g. relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).				
22. The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.				
23. There is evidence that the clinical assessment is culturally relevant (i.e. addresses issues relevant to the enrollee's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.)				
24. There is evidence that the treatment plan is culturally relevant. (i.e., addresses issues relevant to the enrollee's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.)				
25. There is evidence in the record of coordination of care with the PCP or declination of this coordination by the enrollee.				
26. The treatment record has evidence of continuity and coordination of care between behavioral healthcare institutions, ancillary providers and or consultants.				

Standard	Yes	No	N/A	Comments
27. The treatment record reflects evidence of coordination of care with other outpatient behavioral health practitioners				
28. The record reflects evidence of coordination with the EAP/employer if a referral was made.				
Child and Adolescent Records Only – Items 29 – 33				
29. For children and adolescents, prenatal and perinatal events, along with a complete developmental history including physical, psychological, social, intellectual, and academic are documented in the treatment record. N/A if the enrollee is over the age of 18.				
30. The record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the enrollee, unless contraindicated.				
31. The record indicates the parent(s) or caretaker(s) have given signed consent for the various treatments provided.				
32. The record shows evidence of an assessment of school functioning.				
33. The record shows evidence of coordination with the youth's school to achieve school related treatment goals				
Treatment Record-Based Adherence Indicators – Score these items if the diagnosis for any case reviewed is in the 295, 296.2, 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89 or 314 series. Data related to these adherence indicators is used only in the aggregate – it does not enter into the total score/evaluation of the records of this individual practitioner but the results are shared with the practitioner				
Major Depression – 296.2 or 296.3 Series	**Yes**	**No**	**N/A**	
34. Mood symptoms and suicidality are assessed at every visit				
35. Co-morbid problems are assessed upon initial evaluation and at least annually.				
36. 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)				
Schizophrenia – 295 Series	**Yes**	**No**	**N/A**	
37. There is evidence of an assessment of positive signs of psychosis, e.g., delusions and/or hallucinations.				

Standard	Yes	No	N/A	Comments
38. Co-morbid problems are assessed upon initial evaluation and at least annually				
39. 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)				
40. 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; N/A may **not** be checked)				
ADHD – 314.00; 314.01; 314.9	**Yes**	**No**	**N/A**	
41. The record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the enrollee, unless contraindicated. N/A is scored if contraindicated.				
42. Co-morbid problems are assessed upon initial evaluation and at least semi-annually.				
43. The record reflects education about ADHD and parent training in behavioral management.				
44. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A is scored if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g., MSW, PhD)				
45. When medication is prescribed, there is evidence of an evaluation of the enrollee's response to medication and adjustments as needed.				
Bipolar Disorder – 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89 Series	**Yes**	**No**	**N/A**	
46. Mood symptoms and suicidality are assessed at every visit.				
47. Co-morbid problems are assessed upon initial evaluation and at least annually.				
48. 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. N/A is scored for non-prescribing practitioners (e.g. MSW, PhD)				

Co-Occurring Psychiatric and Substance Related Disorders				
List One – Psychiatric Diagnoses: **Major Depression 296.xx** **Bipolar Disorder 296.xx** **Schizophrenia 295.7** **Psychotic Disorder NOS 298.9** **Depressive Disorder NOS 311**		**List Two – Substance Abuse Diagnoses:** **Psychoactive Substance Intoxification or Withdrawal 292.xx** **Psychoactive Substance Induced Disorders 292.xx** **Psychoactive Substance Dependence 304.xx** **Psychoactive Substance Abuse 305.xx**		
Standard	**Yes**	**No**	**N/A**	**Comments**
49. Follow-up after discharge from inpatient care within 7 days				
50. Treatment plan includes identification of barriers to adherence and interventions that address these barriers.				
51. Treatment plan includes relapse plan, including identification of relapse triggers, skills needed to deal with triggers, and contingency plan for difficult instances				
52. Treatment plan includes both SA and psychiatric issues and interventions				
Opioid-Related Disorders – 304.00, 305.50, 292.89x, 292.81x	**Yes**	**No**	**N/A**	
53. Withdrawal evaluation completed within 24 hours to determine the level of detoxification services needed (level I D through level IV D, refer to ASAM PPC-2				
54. The evaluation includes the documentation of consideration of appropriate pharmacotherapy for substance abuse disorder. Rationale is provided for each component of the treatment plan including additional medications				
55. Co-occurring) disorders should be assessed to identify both medical and psychiatric symptoms, which may be masked by substance abuse. If a co-occurring disorder is present, there must be evidence of coordination of care with the medical provider				
56. Evaluation of behaviors correlated with continues use and abuse of illicit drugs				
57. Family/support system involvement in treatment, when appropriate				

General Reviewer Comments:

*** Note: The information is this box is mandatory. If incomplete, the review will not be scored.**

Clinician Reviewer's Signature _____

Clinician Reviewer's Name _____

Clinician Reviewer's Credentials _____

Clinician Reviewer's Phone Number _____

Service Center _____

Date of Review _____