Optum Public Sector San Diego

TREATMENT RECORD REVIEW TOOL

Provider Name	Please select a value...	License Type	LMFT	Reviewer Name	Please select a value...
Date of Review *		Type of Review	Regular		
Audit Period From		Audit Period To			
Client Number		Client Initials *			
Total Audit Score	0	Total Audit Questions	79	Compliance Rate	0 %

Rating Scale: Y = Yes, N = No, N/A = Not Applicable

Administrative

1. Each client has a separate record — **Yes** **No** **N/A**

Comments

2. Each client has emergency contact information. — **Yes** **No** **N/A**

Comments

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. — **Yes** **No** **N/A**

Comments

4. For 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. — **Yes** **No** **N/A**

Comments

5. Notice of Privacy Practices has been provided as required by HIPAA. — **Yes** **No** **N/A**

Comments

6. There is a written protocol for accommodating clients in a life threatening emergency. — **Yes** **No** **N/A**

Comments

7. The provider makes arrangements for emergency coverage for all clients 24 hours per day/7 days per week. (Review how coverage is provided) — **Yes** **No** **N/A**

Comments

8. Information is provided to clients which includes a description of services. — **Yes** **No** **N/A**

Comments

9. Information is provided to clients which includes the hours during which care and services are available and is comparable to non Medi-Cal clients. — **Yes** **No** **N/A**

Comments

10. Information is provided to clients which includes an explanation of the cancellation/no-show policy. — **Yes** **No** **N/A**

Comments

11. Clients are informed they have a right to refuse to participate in treatment. ○ **Yes** ○ **No** ○ **N/A**

Comments

12. Clients are informed that information about them and their families is protected and kept confidential. ○ **Yes** ○ **No** ○ **N/A**

Comments

13. There is documentation the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options. ○ **Yes** ○ **No** ○ **N/A**

Comments

14. There is documentation that reflects the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian. ○ **Yes** ○ **No** ○ **N/A**

Comments

15. There is documentation 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. ○ **Yes** ○ **No** ○ **N/A**

Comments

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. ○ **Yes** ○ **No** ○ **N/A**

Comments

General Documentation Standards

17. The record is clearly legible to someone other than the writer. ○ **Yes** ○ **No** ○ **N/A**

Comments

18. All entries (including but not limited to progress notes, treatment plans, 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. ○ **Yes** ○ **No** ○ **N/A**

Comments

19. If the client has limited English proficiency, there is documentation that interpreter services were offered. ○ **Yes** ○ **No** ○ **N/A**

Comments

20. If interpreter services were offered, there is documentation indicating whether the client accepted or declined the services. ○ **Yes** ○ **No** ○ **N/A**

Comments

21. **For Medication Services only:** Record includes a medication log with dosages of each medication, dates of initial prescription and refills. ○ **Yes** ○ **No** ○ **N/A**

Comments

Assessment

22. The reasons for admission or initiation of treatment are indicated. ○ **Yes** ○ **No** ○ **N/A**

Comments

23. A behavioral health history is included in the record. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

24. A medical history including any current medical conditions is included in the record. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

25. Record includes current medications with the name of the prescriber. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

26. The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

27. 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. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

28. The behavioral health treatment history includes the following information: dates of previous treatment, providers of previous treatment, and therapeutic interventions and responses. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

29. Initial assessment identifies client strengths. If the client is a child or adolescent, family strengths are included. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

30. The behavioral health treatment history includes family history information. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

31. 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. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

32. The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

33. 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. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

34. The assessment documents a sexual history to include orientation, gender identity and high risk behaviors (as applicable). ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

35. **For children and adolescents:** a complete developmental history (physical, psychological, social, intellectual and academic) is documented. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

36. The record documents the cultural variables that may impact treatment. ◯ Yes ◯ No ◯ N/A

Comments

37. The record documents the presence or absence of relevant legal issues of the client and/or family. ◯ Yes ◯ No ◯ N/A

Comments

38. 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. ◯ Yes ◯ No ◯ N/A

Comments

39. 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. ◯ Yes ◯ No ◯ N/A

Comments

40. For clients 12 and older, the substance abuse screening includes documentation of past and present use of nicotine. ◯ Yes ◯ No ◯ N/A

Comments

41. If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.. ◯ Yes ◯ No ◯ N/A

Comments

42. A Title 9 Medi-Cal included primary treatment diagnosis is present in the record and consistent with assessment data. ◯ Yes ◯ No ◯ N/A

Comments

Treatment Planning (For prescribers, the psychotropic informed consent acts as the treatment plan when providing medication management services.)

43. There is evidence the assessment is used in developing the treatment plan and goals. ◯ Yes ◯ No ◯ N/A

Comments

44. The treatment plan is consistent with the diagnosis. ◯ Yes ◯ No ◯ N/A

Comments

45. 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. ◯ Yes ◯ No ◯ N/A

Comments

46. The treatment plan goals are specific, observable and quantifiable. ◯ Yes ◯ No ◯ N/A

Comments

47. The treatment plan goals identify the proposed type(s) of intervention. ◯ Yes ◯ No ◯ N/A

Comments

48. The treatment plan has estimated time frames for goal attainment. ◯ Yes ◯ No ◯ N/A

Comments

49. The treatment plan is updated whenever goals are achieved or new problems are identified. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

50. The treatment plan is reviewed and updated with the client at regular intervals. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

51. The treatment record documents and addresses biopsychosocial needs. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

52. The treatment record indicates the client's involvement in care and service. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

53. When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

Progress Notes

54. All progress notes document the date of service rendered. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

55. All progress notes document the length of service rendered when providing a timed service. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

56. All progress notes document clearly who is in attendance during each session. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

57. All progress notes include documentation of the diagnosis for the session. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

58. All progress notes for group therapy are properly apportioned to all clients present. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

59. The progress notes reflect reassessments when clinically indicated. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

60. The progress notes reflect on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at-risk situations. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

61. Safety plan is created when active safety risks are identified. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

62. Safety plan is revisited after each crisis/SI/SA/HI/high-risk event. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

63. The progress notes document billable services according to Title 9 requirements. ◯ Yes ◯ No ◯ N/A

Comments

64. The progress notes describe progress or lack of progress towards treatment plan goals. ◯ Yes ◯ No ◯ N/A

Comments

65. The progress notes document the date or timeframe of follow up appointments. ◯ Yes ◯ No ◯ N/A

Comments

66. The progress notes document when clients miss appointments and these services are not claimed. ◯ Yes ◯ No ◯ N/A

Comments

67. The progress notes document referrals made to other providers, agencies, and/or therapeutic services when indicated. ◯ Yes ◯ No ◯ N/A

Comments

68. If an Outpatient Authorization Request (OAR) was completed for continued authorization, progress notes document all concerns identified. ◯ Yes ◯ No ◯ N/A

Comments

69. The progress notes document medical necessity in all relevant aspects of client care. ◯ Yes ◯ No ◯ N/A

Comments

Coordination of Care

70. The record documents the client was asked whether he/she has a primary care physician (PCP). If applicable, includes PCP name and contact information. ◯ Yes ◯ No ◯ N/A

Comments

71. 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). ◯ Yes ◯ No ◯ N/A

Comments

72. 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. ◯ Yes ◯ No ◯ N/A

Comments

73. The record documents evidence of communication with other behavioral health provider(s) when clinically indicated. ◯ Yes ◯ No ◯ N/A

Comments

Discharge and Transfer

74. If the client was transferred/discharged to another provider or program, there is documentation that communication/collaboration occurred with the receiving provider/program, or was attempted. ◯ Yes ◯ No ◯ N/A

Comments

75. When applicable, the treatment record reflects discharge planning. ◯ Yes ◯ No ◯ N/A

Comments

76. Record documents a discharge summary, or appropriate follow-up efforts if the client terminated prematurely. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

77. The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

78. The discharge/aftercare/safety plan describes specific follow-up activities. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

79. Clinical records are completed within 30 days following discharge or last date of service. ◯ **Yes** ◯ **No** ◯ **N/A**

Comments

Final Comment

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