January-21

Optum Idaho

Treatment Record Review Form

Facility Name:

Reviewer Name:

Member Gender:

Member Age:

Diagnosis:

Date of Review:

Rating Scale: NA = Not Applicable Y = Yes N = No		Y	N	NA
General Documentation				
1	Each member has a separate record.			
2	Each record includes the member'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 (including electronic signature for EMR systems) where appropriate.			
Initial Assessment				
4	A DSM primary treatment diagnosis is in the record.			
5	A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments.			

6	The presenting problem and conditions are documented.			
7	A behavioral health history is in the record.			
8	The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.			
9	The behavioral health treatment history includes family history information.			
10	A medical history is in the record.			
11	The medical treatment history includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.			
12	The medical treatment history includes family history information.			
13	Was a current medical condition identified? This is a non-scored question. (If #10 is N, then #13 is N/A)			
14	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			

15	If a medical condition was identified, there is documentation that the member/guardian refused consent for the release of information to the treating medical clinician. This is a non-scored question.			
16	A complete mental status exam is in the record, documenting the member's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.			
17	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 any behaviors that could be considered a danger toward self or others.			
18	The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality as well as any behaviors that could be considered a danger toward self or others.			
19	The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse.			
20	The behavioral health history includes an assessment of any trauma the member has experienced.			
21	For Adolescents: The assessment documents a sexual behavior history.			
22	For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.			
23	For members under the age of 19, there is evidence that the Child and Adolescent Needs and Strengths (CANS) assessment was completed and or updated, and was utilized to identify the member specific functional need(s).			

24	The initial screen includes an assessment for depression.			
25	For members 10 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.			
26	For members 10 and older, the substance abuse screening includes documentation of past and present use of nicotine.			
27	When an active substance issue is identified, the ASAM 6 Dimension Assessment and placement determination (as appropriate) is in the record, and was completed by an individual specifically trained to complete this assessment.			
28	If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
29	The substance identified as being misused was alcohol. **This is a non-scored question.**			
30	The substance(s) identified as being misused were substance(s) other than alcohol. **This is a non-scored question.**			
31	The substances identified as being misused were alcohol and other substance(s). **This is a non-scored question.**			
32	The assessment documents the spiritual variables that may impact treatment.			

33	The assessment documents the cultural variables that may impact treatment.			
34	An initial treatment plan with goals, treatment priorities, and milestones for progress is in the record.			
35	An educational assessment appropriate to the member's age is documented.			
36	The record documents the presence or absence of relevant legal issues of the member and/or family.			
37	There is documentation that the member was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			
38	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
39	The member's previous medication history is documented in the record.			
40	The clinician uses a Consent for Treatment or Informed Consent form with all members; this document should be signed by the member and/or legal guardian.			
41	There is evidence that the assessment is used in developing the treatment plan and goals.			

42	On an annual basis, the member is reassessed. This includes the member's current status and a new mental status exam.			
43	The documentation in the treatment record includes the onset, duration, and frequency of the symptoms the member is experiencing.			
44	The documentation in the treatment record identifies functional needs the member is experiencing, and how they will be addressed in the treatment services.			
Coordination of Care				
45	The name of the member's primary care physician (PCP) documented in the record (All members should have a PCP; if not, they should be referred to a PCP.)			
46	The record documents that the member was asked whether they have a PCP. **Y or N Only**			
47	If the member has a PCP there is documentation that communication/collaboration occurred.			
48	If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP			
49	Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor) and/or were they seen by another behavioral health clinician in the past? **This is a non-scored question.**			
50	The record documents that the member was asked whether they are being seen by another behavioral health clinician.			

51	If the member has another behavioral health clinician there is documentation that communication/collaboration occurred.			
52	If the member has another behavioral health clinician, there is documentation that the member/guardian refused consent for the release of information to the other behavioral health clinician.			
53	For members who are receiving some behavioral health or substance use disorder service at another agency, there is evidence in the record of active case consulting with the other service provider.			
Person-Centered Care				
54	A specific service plan is in place that is geared towards the individual member's needs and strengths.			
55	The treatment plan includes treatment goals in the member's own words.			
Documentation Related to the Treatment Plan				
56	There is documentation (a signed form or in progress note) that the member or legal guardian (based on each state's age of consent) has agreed to the treatment plan.			
57	The treatment plan is consistent with the diagnosis.			
58	For members 19 years of age and under, there is evidence that the results of the CANS was used in developing the treatment plan.			
59	The treatment plan has short term measurable goals.			

60	The treatment plan has long term goals.			
61	The treatment plan includes the identified interventions, including who is responsible.			
62	The treatment plan includes a safety plan when active risk issues are identified.			
63	The treatment plan has measurable objectives.			
64	The treatment plan has estimated time frames for goal attainment.			
65	The identified interventions in the treatment plan are appropriate for the member based on their individual needs and strengths.			
66	The treatment plan is updated whenever goals are achieved or new problems are identified.			
67	When applicable, the treatment record, including the treatment plan, reflects discharge planning.			
68	If a member is receiving services in a group setting, there is evidence of an individualized assessment, treatment planning, and progress notes in response to identified member needs.			

69	The treatment record documents and addresses biopsychosocial needs.			
70	The treatment record indicates the member's involvement in care and service.			
71	When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.			
Progress Notes				
72	For all Outpatient Services: All progress notes document the start and stop times for each session when a timed CPT Code is used.			
73	For all Outpatient Services: All progress notes document clearly who is in attendance during each session.			
74	For all Outpatient Services: All progress notes include documentation of the billing code, or the specific service, that was provided.			
75	The progress note indicates the type of intervention that was used for the session.			
76	The progress notes reflect reassessments when necessary.			
77	The progress notes reflect on-going risk assessments (including but not limited to suicide, homicide, and dangerous behaviors) and monitoring of any at risk situations.			

78	The progress notes describe/list member needs and strengths and how those impact treatment.			
79	The progress notes describe progress or lack of progress towards treatment plan goals.			
80	The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.			
81	The progress notes document the use of any preventive services (relapse prevention, stress management, wellness programs and referrals to community resources).			
82	If the member is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)			
83	When a primary care physician is identified, there is evidence the prescriber coordinated care within 14 calendar days after initiation of a new medication. ***This is a non-scored question.***			
	If there is evidence of coordination of care outside of 14 calendar days, document how many days after initiation the coordination took place.			
84	There is documentation that indicates the member understands and consents to the medication used in treatment.			
85	For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.			
86	Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.			

87	When lab work is ordered, there is evidence the lab results were received and reviewed by the provider.			
88	When lab work is ordered, there is evidence that the provider reviewed the results with the member.			
89	The progress notes document the dates of follow up appointments.			
90	The progress notes document when members miss appointments.			
91	When a member misses an appointment, there is documentation of outreach efforts (phone calls, missed appointment letters) the provider makes to reengage the member in treatment.			
Transition of Care				
92	Was the member transferred/discharged to another clinician or program? **This is a non-scored question.**			
93	If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
94	If the member was transferred/discharged to another clinician or program, there is documentation that the member/guardian refused consent for release of information to the receiving clinician/program.			
95	The reason for discharge is clearly identified.			

96	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
97	The discharge/aftercare plan describes specific follow up activities.			
Treatment Records				
98	Treatment records are completed within 30 days following discharge.			
99	The record is clearly legible to someone other than the writer.			
100	When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)			
Education				
101	There is documentation that the provider offers education to members/families about care options, participation in care and coping with behavioral health problems.			
102	There is documentation that the provider offers education to members/families about prognosis and outcomes.			
103	There is documentation that the risks of not participating in treatment are discussed with the member.			
ALERT				

104	FOR OUTPATIENT SERVICES ONLY: There is a completed wellness assessment (or documentation that the member refused to complete a wellness assessment) in the record.			
Interpreter Services				
105	If the member has limited English proficiency, there is documentation that interpreter services were offered, and whether or not the services were accepted or declined.			
Recovery and Resiliency				
106	The member is given information to create psychiatric advance directives when appropriate. This is a non-scored question.			